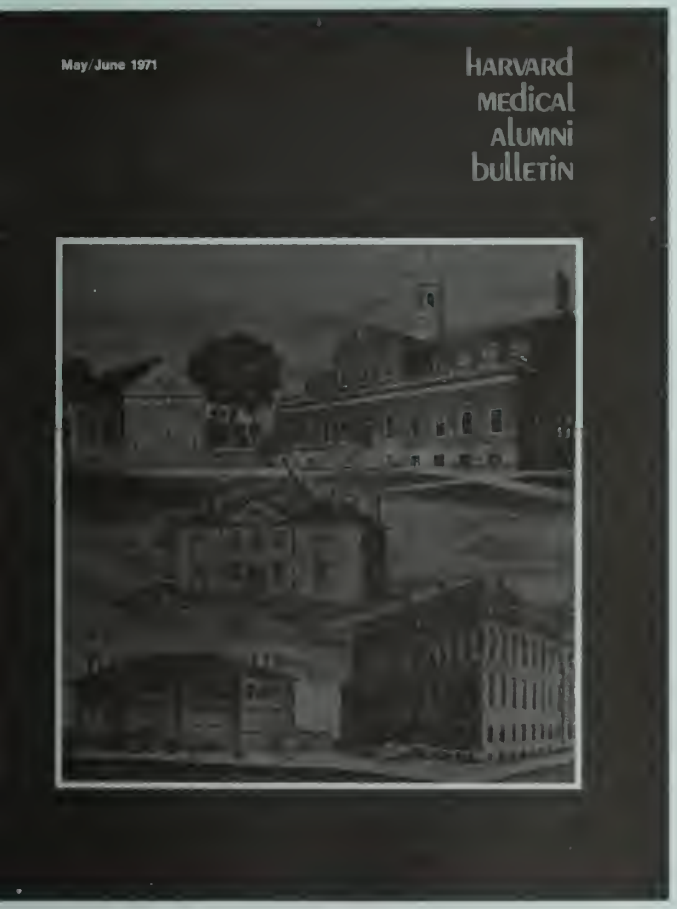
HARVARD MEDICAL ALUMNI BULLETIN

July/August 1972


The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longe
take breathing for granted.

Would you like to contribute
your share of the cost of the

HARVARD MEDICAL ALUMNI BULLETIN?



The total operating cost of the Alumni Bulletin is $60,000 annually. It is sent, without charge, to 6,000 Alumni and students.

Notes for the Bulletin

NAME: CLASS:

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

The positive power of

Libritabs®
(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.

up to 100 mg daily

for severe anxiety accompanying congestive heart failure

ROCHE

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Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

SPECIAL REDUCED RATES FOR HARVARD ALUMNI

EIGHTH ANNUAL TOUR PROGRAM—1972

This unique program of tours is offered to alumni of Harvard, Yale, Princeton, M.I.T., Cornell, Dartmouth, Univ. of Pennsylvania and certain other distinguished universities and to members of their families. The tours are based on special reduced air fares which offer savings of hundreds of dollars on air travel. These special fares, which apply to regular jet flights of the major scheduled airlines but which are usually available only to groups and in conjunction with a qualified tour, are as much as $500 less than the regular air fare. Special rates have also been obtained from hotels and sightseeing companies.

The tour program covers areas where those who might otherwise prefer to travel independently will find it advantageous to travel with a group. The itineraries have been carefully constructed to combine the freedom of individual travel with the convenience and savings of group travel. There is an avoidance of regimentation and an emphasis on leisure time, while a comprehensive program of sightseeing ensures a visit to all major points of interest. Hotel reservations are made as much as a year and a half in advance to ensure the finest in accommodations.

EAST AFRICA

22 DAYS $1699

A luxury "safari" to the great national parks and game reserves of Uganda, Kenya and Tanzania. The carefully planned itinerary offers an exciting combination of East Africa's spectacular wildlife and breathtaking natural scenery: great herds of elephant and a launch trip through hippo and crocodile in **MURCHISON FALLS NATIONAL PARK**; multitudes of lion and other plains game in the famed **SERENGETI PLAINS** and the **MASAI-MARA RESERVE**; the spectacular concentration of wildlife in the **NGORONGORO CRATER**; tree-climbing lions around the shores of **LAKE MANYARA**; the **AMBOSELI RESERVE**, where big game can be photographed against the towering backdrop of snow-clad Mt. Kilimanjaro; and the majestic wilds of **TSAVO PARK**, famed for its elephant and lion as well as its unusual Mzima Springs. Also included are a cruise on **LAKE VICTORIA** in Uganda and visits to the fascinating capital cities of **KAMPALA** and **NAIROBI**. The altitude in East Africa provides an unusually stimulating climate, with bright days and crisp evenings (frequently around a crackling log fire), and the tour follows a realistic pace which ensures a full appreciation of the attractions visited. Total cost is $1699 from New York. Optional extensions are available to the famed **VICTORIA FALLS**, on the mighty Zambezi River between Zambia and Rhodesia, and to the historical attractions of **ETHIOPIA**. Departures in January, February, March, May, June, July, August, September, October, November and December 1972 ($25 additional for departures in June, July, August).

THE ORIENT

30 DAYS $1759

1972 marks the eighth consecutive year of operation for this outstanding tour, which offers the greatest attractions of the Orient at a sensible and realistic pace. Twelve days are devoted to the beauty of **JAPAN**, visiting the ancient "classical" city of **KYOTO**, the modern capital of **TOKYO**, and the lovely **FUJI-HAKONE NATIONAL PARK**, with excursions to ancient **NARA**, the magnificent medieval shrine at **NIKKO**, and the giant Daibutsu at **KAMAKURA**. Visits are also made to **BANGKOK**, with its glittering temples and palaces; the fabled island of **BALI**, considered one of the most beautiful spots on earth; the ancient temples near **JOGJAKARTA** in central Java; the mountain-circled port of **HONG KONG**, with its free port shopping; and the cosmopolitan metropolis of **SINGAPORE**, known as the "cross-roads of the East." Tour dates include outstanding seasonal attractions in Japan, such as the spring cherry blossoms, the beautiful autumn leaves, and some of the greatest annual festivals in the Far East. Total cost is $1759 from California, $1965 from Chicago, and $2034 from New York, with special rates from other cities. Departures in March, April, June, July, September and October 1972.

AEGEAN ADVENTURE

22 DAYS $1329

This original itinerary explores in depth the magnificent scenic, cultural and historic attractions of Greece, the Aegean, and Asia Minor—not only the major cities but also the less accessible sites of ancient cities which have figured so prominently in the history of western civilization, complemented by a luxurious cruise to the beautiful islands of the Aegean Sea. Rarely has such an exciting collection of names and places been assembled in a single itinerary—the classical city of **ATHENS**; the Byzantine and Ottoman splendor of **ISTANBUL**; the site of the oracle at **DELPHI**; the sanctuary and stadium at **OLYMPIA**, where the Olympic Games were first begun; the palace of Agamemnon at **MYCENAE**; the ruins of ancient **TROY**; the citadel of **PERGAMUM**; the marble city of **EPHESUS**; the ruins of **SARDIS** in Lydia, where the royal mint of the wealthy Croesus has recently been unearthed; as well as **CORINTH**, **EPIDAUROS**, **IZMIR** (Smyrna) the **BOSPORUS** and **DARDENELLES**. The cruise through the beautiful waters of the Aegean will visit such famous islands as **CRETE** with the Palace of Knossos; **RHODES**, noted for its great Crusader castles; the windmills of picturesque **MYKONOS**; the sacred island of **DELOS**; and the charming islands of **PATMOS** and **HYDRA**. Total cost is $1329 from New York. Departures in April, May, July, August, September and October, 1972.

MOGHUL ADVENTURE

29 DAYS $1725

An unusual opportunity to view the outstanding attractions of India and the splendors of ancient Persia, together with the once-forbidden mountain kingdom of Nepal. Here is truly an exciting adventure: India's ancient mounuments in **DELHI**; the fabled beauty of **KASHMIR** amid the snow-clad Himalayas; the holy city of **BANARAS** on the sacred River Ganges; the exotic temples of **KHAJURAHO**; renowned **AGRA**, with the Taj Mahal and other celebrated monuments of the Moghul period such as the Agra Fort and the fabulous deserted city of Fatehpur Sikri; the walled "pink city" of **JAIPUR**, with an elephant ride at the Amber Fort; the unique and beautiful "lake city" of **UDAIPUR**; a thrilling flight into the Himalayas to **KATHMANDU**, capital of **NEPAL**, where ancient palaces and temples abound in a land still relatively untouched by modern civilization. In **PERSIA** (Iran), the visit will include the great 5th century B.C. capital of Darius and Xerxes at **PERSEPOLIS**; the fabled Persian Renaissance city of **ISFAHAN**, with its palaces, gardens, bazaar and famous tiled mosques; and the modern capital of **TEHERAN**. Outstanding accommodations include hotels that once were palaces of Maharajas. Total cost is $1725 from New York. Departures in January, February, August, October and November 1972.

Rates include Jet Air, Deluxe Hotels, Most Meals, Sightseeing, Transfers, Tips and Taxes. Individual brochures on each tour are available.

For Full Details Contact:

ALUMNI FLIGHTS ABROAD
White Plains Plaza
One North Broadway
White Plains, N.Y. 10601

HARVARD MEDICAL ALUMNI BULLETIN
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CONTENTS

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COVER: New directions in the Harvard Medical Alumni Association will be guided by (l. to r.) Perry J. Culver '41, Director of Alumni Relations; Robert H. Ebert, Dean, HMS; and Carl W. Walter '32, newly-appointed Chairman of the Harvard Medical Alumni Fund. For related story, see page 4.

CREDITS: Cover, Bradford F. Herzog; Rick Stafford, pp. 4, 10, 12, 15-18, 22-25, 27-29, 32, 37; Fay Photo Service, pp. 34, 36; Courtesy of National Council on Alcoholism, p. 43; White Star Photo Service, p. 57.

OVERVIEW

Council Deliberates Future Directions

The third and final meeting of the Alumni Council for the current academic year took place on June 1, 1972. All councilors were present except John W. Kirklin '42 who was unavoidably detained.

In the balloting for councilors the following were elected:

Daniel D. Federman '53
William W. Southmayd '68
Jesse E. Thompson '43A

Signed ballots numbered 2,215; in addition, there were 64 unsigned. By way of interesting aberration, one alumnus submitted a carefully signed and checked ballot of nominees for the previous year. There was a discussion about the necessity of signing ballots. It was felt that this may deter some from casting a ballot because of their desire for their votes to be anonymous. A study will be made to determine whether the process employed by the Associated Harvard Alumni will be followed whereby ballots are unsigned but are submitted in a signed envelope which is then discarded after the individual voter has been checked off. Further discussion about councilor elections was engendered by the fact that some alumni complained of difficulties in making a wise choice among candidates in as much as they had only the curricula vitae to go by. There are plans to explore the possibility for each candidate to submit a short statement of his stand on some specific problems related to the Medical School. In addition, it was suggested that the nominations for the Council be made at an earlier date in order to provide a longer lead time prior to balloting for developing additional information about each candidate, not only for the Harvard Medical Alumni Council, but also for the Board of Overseers and the Directors of the Associated Harvard Alumni. The regional alumni groups of the Harvard Medical School will be solicited for names of possible candidates thus providing a broader selection of nominees.

The officers of the Alumni Association were also nominated and voted upon at the annual meeting of the Association on Alumni Day, June 2, 1972. The following were elected: president (1972-73), John H. Talbott '28; president-elect (1972-73), Claude E. Welch '32; secretary (1972-75), Franz J. Ingelfinger '36; representative to Associated Harvard Alumni (1972-74), Gordon A. Donaldson '35.

George S. Richardson '46, editor of the *Alumni Bulletin*, gave an informative report regarding his philosophy and plans for the future of the *Bulletin*. He hopes the HMAB will be increasingly entertaining and all will be stimulated to read it. To this end, he and Joan F. Rafter, managing editor, are planning to have shifting topics from issue to issue with a variety of major subjects including some that are controversial. A new department of the Bulletin, "Reminiscences," under the direction of Herrman L. Blumgart '21, has been well received and all alumni are urged to contribute to "Reminiscences" which, if received in sufficient quantity, may be compiled into a book. The problem of adequate alumni notes was discussed. The natural hesitation of many people to report on their own activities appears to be one cause of a paucity of notes. An effort will be made to identify a reporter or corresponding secretary in the various major regions where alumni are concentrated, with the hope that these individuals will provide a steady flow of information about alumni in their area. It was also suggested that the talks given by Dean Ebert around the country would be of great interest to alumni everywhere and would be a means of further communicating news about the school.

Dr. Walter

A progress report on annual giving showed that the average gift and the total amount contributed this year, when compared with the year previous was actually greater, but the number of donors was down by about 400. A final reporting of annual giving will be made in the Fund Report which will appear early in the fall.

During the discussion of annual giving, the Alumni Council appointed with great enthusiasm, Carl W. Walter '32 as chairman of the Harvard Medical Alumni Fund. Dr. Walter, who has been very devoted to the affairs of the Medical School and most generous in his support, has accepted this position and has promised, with his usual vigor, to strengthen the role and position of class agents and hopes to develop a much greater percentage of participation in alumni giving. He will work closely with the Alumni Office, Alumni Council, and regional alumni groups.

A discussion followed on the need to consider new elections of class officers and class agents at each five year reunion. Class officers are sometimes incapacitated or lose in-

terest; reelection every five years will permit those who no longer wish to be an officer to "get off the hook" and bring forth alumni who will work to promote the interest of their class. Some class agents have expressed a desire to be replaced and other are most eager to continue in their role. Whether class agents should be elected or whether enthusiastic and productive individuals should be indentified and appointed by Dr. Walter is to be examined. An ad hoc committee to study the entire problem and make recommendations was appointed by President Talbott and consisted of Carl W. Walter '32, Perry J. Culver '41, and Roman W. DeSanctis '55.

The budgets of the Alumni Office and the *Alumni Bulletin* were presented and discussed. In as much as the Alumni Office and *Bulletin* are both designed for service to the alumni, it was recommended and accepted that these budgets be part of the ordinary operating budgets of the Dean's Office and in this way, all annual giving from the alumni can be used for financial aid support for medical students. It was noted that the budget for the *Alumni Bulletin* amounts to $60,000 for the 6,300 alumni. Discussion revolved around the fact that many alumni might be willing to make an additional tax deductible contribution to the Medical School equal to his individual share of the cost of publishing the *Bulletin*. In this issue of the *Bulletin* there is a flyer soliciting a $10.00 contribution.

In discussing regional alumni activities there was consideration of ways in which the Alumni Association might be able to sponsor continuing education programs designed specifically for the benefit of the Harvard Medical alumni. Discussion about this topic was general and introductory; many details and problems remain to be explored, and will be during future Alumni Council meetings. A major regional alumni activity during recent months was a cocktail party and reception at the Bohemian Club in San Francisco on Monday, June 19, 1972. Ninety-one alumni and wives were present at a most delightful party. John H. Talbot '28, president, and Claude E. Welch '32, president-elect were introduced, as was Mr. Brent M. Abel, Harvard College '37, president of the Associated Harvard Alumni.

Noted Immunologist Named Gamble Professor of Pediatrics

The first James L. Gamble Professor of Pediatrics at Harvard is Fred S. Rosen, M.D., a noted clinical immunologist who has made extensive contributions to the treatment of inherited deficiencies in the abilities of newborn infants to withstand infections. Dr. Rosen will serve at the Children's Hospital Medical Center, where he is chief of the division of immunology in the department of pediatrics. He has been associated with HMS and TCH since 1959.

Highly regarded as a perceptive and dedicated physician to the young, Dr. Rosen received his A.B. degree from Lafayette College in 1951 and the M.D. degree from Western Reserve University in 1955. He did his internship and residency at TCH in the departments of pathology and pediatrics. In 1957-59 Dr. Rosen was a research officer assigned to the Laboratory of Chemical Pharmacology, National Cancer Institute, National Institutes of Health. One of his central interests is the study of a complex group of proteins of the blood, known as the complement system, and he has identified several inherited deficiencies of individual components of the system, some of which result in disease. With his colleagues, Dr. Rosen also has made important contributions to the growing field of lymphoid cell restoration by transplantation in infants in whom there is an inherited deficit of lymphoid cells or in those born without a thymus gland. In addition to his extensive research work, Dr. Rosen is also highly regarded as a teacher, and has demonstrated his ability to stimulate and attract young investigators to work with him.

James L. Gamble '10 is honored by the professorship established in his name. He dedicated his life to the study of disease by the methods of chemistry. In a biographical memoir published by the National Academy of Sciences, Richard F. Loeb '19 wrote: "[He was] one of a small group of pioneers in this country, trained in clinical medicine, but with the vision to recognize that not only practical benefits to man's welfare but also many of the fundamental problems of biology are to find their solution in the study of man in health and disease."

In 1922 Dr. Gamble was appointed assistant professor of pediatrics, after serving with the armed services during the first world war, and Johns Hopkins University Medical School in the first full-time department of pediatrics to be established in the United States. In 1932 Dr. Gamble was promoted to professor; 1941-45 found him serving as editor of the *Journal of Clinical Investigation,* and in 1950, after his retirement, he was named professor emeritus and continued on as director of the Metabolic Research Laboratory at the Children's Hospital Medical Center.

In 1961, the Gamble Professorship was established by Harvard with a gift from Mrs. Elizabeth C. Gamble, Dr. Gamble's widow. Colleagues, family, and friends of Dr. Gamble contributed to the fund.

Among the many honors Dr. Gamble received was the Kober Medal of the Association of American Physicians (1951), the John Howland Award of the American Pediatric Society (1955) and the knowledge that he was one of a very small number of physicians to be elected to the National Academy of Sciences. Dr. Gamble died in 1959.

"Tomorrow's World and Human Welfare" Theme of Dedication Ceremonies at the Laboratory of Human Reproduction and Reproductive Biology

Day-long ceremonies marked the dedication of the Laboratory of Human Reproduction and Reproductive Biology at HMS on May 8. The building, whose construction costs exceeded four million dollars is located adjacent to Building A. The Laboratory will direct its resources to clarifying the basic psysiological processes of reproduction.

The theme of the dedication day festivities was "Tomorrow's World and Human Welfare." Roy O. Greep, Ph.D., John Rock Professor of Population Studies, Harvard School of Public Health, and director of the new Laboratory presided. Speakers were: Roger R. D. Revelle, Ph.D., Richard Saltonstall Professor of Population Studies, HSPS; Bernard Berelson, Ph.D., president, Population Council; Louis M. Hellman, M.D., deputy assistant secretary for population affairs, Department of Health, Education, and Welfare; and John D. Biggers, Ph.D., Professor of Physiology, HMS.

The dedication of the new Laboratory took place at 3:00 P.M. and included in the ceremony were: Oscar Harkavy, Ph.D., director of the population program, The Ford Foundation; Philip A. Corfman '54, director, Center for Population Research, National Institute of Child Health and Human Development; and Robert H. Ebert, Dean of the Medical School.

Functioning as an interdisciplinary center, investigators with widely divergent skills and backgrounds work together on problems of reproductive biology. Basic knowledge of reproduction, and especially of human reproductive functions, has lagged far behind the increase in knowledge of other biological systems in man, according to Dr. Greep. Yet, over-population is widely recognized now as one of the world's most pressing problems. The broad scope of research to be pursued at the Laboratory will bring modern scientific and technological advances in this and related fields to bear in the solution of problems in reproduction.

There are 37 scientists now occupying space in the facility, which has a total of 63,400 square feet of floor space. The major funds for construction were provided by The Ford Foundation, the Rockefeller Foundation, the Avalon Foundation, and the United States Public Health Service. A $1,500,000 grant from the Rockefeller Foundation will be used for support of the faculty and staff of the Laboratory over a ten-year period.

Laboratory of Human Reproduction and Reproductive Biology

editorials

Tax-deductible Reading for Pleasure

Your *Harvard Medical Alumni Bulletin* comes to you without charge as a gift of the Harvard Medical Alumni Association. The Editors of the *Bulletin* hope that you enjoy the gift, and that it tells you what you want to know about HMS, its hopes and plans. We would like to know, too, if you have different ideas about the *Bulletin* — its news, its articles, its pictures — and, if you feel moved to submit an article, we'd be delighted to consider it.

In this issue, for the first time, we include a flyer in which we ask you, if you wish, to make a tax-deductible gift to Harvard of the cost of the *Bulletin*. If you can, and will, Harvard will be able to apply the money where it is sorely needed — and the hard working staff of the *Bulletin* will know that their labors are really of service!

I should like to take this opportunity as Editor to add a personal appeal to readers to increase their gifts to HMS, or to begin to give if you have not done so before. It is so clear to us who are close to Building A that every effort is made to provide support for students with financial problems, and that funding falls short of the full potential. If more of us would try to repay Harvard the value of our medical education — and how that value has appreciated with the years! — we could soon provide full scholarship funding for our successors, and in good measure.

REMINISCENCES

With music swiped from Sir Arthur Sullivan and words that would have made Mr. Gilbert pop-eyed (exophthalmic).

Especially composed for the meeting of Course 488, Harvard Postgraduate Ophthalmology on December 13th, 1950.

BY DAVID G. COGAN '32

I am the very model of a model ophthalmologist,
With knowledge so extensive I've no need for an apologist.
I'm quite equipped to handle any ocular adversity:
I took my basic science course at Harvard University.
I've learned ten million facts or so and I know what to do with them;
They're firmly locked within my brain and I recall a few of them.
My reputation for such intellectual fecundity
Insures that none can doubt my diagnostical profundity.
So when I start to practice on the public bulbus oculi,
I'm confident — and hopeful — that the customers will flock to me.
With knowledge so extensive, I've no need for an apologist;
I am the very model of a model ophthalmologist.

My grasp of eye anatomy leaves nothing that's correctable;
I've cut out every structure that is possibly dissectible.
Discourses on Zinn's annulus or ciliary ganglion
Are just my dish, they're subjects which no one can ever hang me on.
I know of every muscle that's at all concerned with human sight;
I call it "Muller's" when in doubt and half the time I'm bloomin' right!
There's not a cell or fiber microscopically unknown to me;
I have a name for each, including artifacts I'm prone to see.
On Schlemm's canal I speak at length; I'm sure I'll never get in a
Discussion that can quite exhaust my knowledge of the retina.
So versed am I in each detail — an ocular histologist,
I am the very model of a model ophthalmologist.

My studies in neurology are even now notorious;
I modeled every nucleus that's oculomotorius;
I followed every fiber tract; no one was more meticulous
Exploring all the stops along the median fasciculus.
Long hours I spent to culture the pestiferous bacterium;
I specialized to recognize and septicise — ad weary-um!
For optics I've a special bent, and factors aberrational
I write in sines and tangents with results oft' quite sensational.
In fact I know each angle of this complicated business,
Though kappa, alpha and the rest have caused me untold dizziness.
Completely trained as any mathematical biologist,
I am the very model of a model ophthalmologist.

There's nothing basic to the eye left out of my curriculum;
It saturates my hemispheres and squeezes one colliculum!
No facts are left for me to gain in knowledge of the aqueous,
And I can promptly recognize a cataract opaqueous;
The slitted lamp reveals to me all things that may be seeable;
In short, my erudition brings a feeling most agreeable.
So though I feign, now and again, a manner lackadaisical,
This point I wish to emphasize: My sciences are basical.
Thus when, in time, I stand before St. Peter's bright and weighty gate,
And in his book 'tis writ: "He took Fair Harvard's Course Four-
eighty-eight,"
I know they'll welcome me in terms that echo my necrologist:
"He was the very model of a model ophthalmologist!"

books

The Yachtsman's Guide to Dining Out in Maine, edited by Paul W. Davis '47, Old Greenwich, Connecticut, The Yachtsman's Guide to Dining Out Company, Division of Guidebook Press 1971, 46 pages, $2.50.

The book covers moderately well the larger, more commercial harbors and a few that are not so large or so commercial. There are omissions: Kobs in Searsport is one. There are others. But the book is obviously written for the eater who owns a power boat.

I like to think of this as being an introduction for the newcomer to the glorious coast of Maine. Surely once he has had a chance to see a few of the harbors and restaurants covered, the following year he will want to go to more quiet coves and inlets where only hard, granite rocks and spruce trees can be seen. He and his wife will cook a steak and enjoy their meal "on board." Before or after dinner, he can row ashore and explore "his" uninhabited island and get a refreshing sense of "being away from it all."

However, there are times when, after several days aboard a boat, one looks forward to a good meal cooked by someone else. Here is a book which will supply adequate information so that such a spot can be found.

Do not rely on the charts in the booklet, you will need more help to get into and out of these harbors. But whatever you do — get east and see the lovliest coast line in the world.

JOHN R. BROOKS '43B

PROMOTIONS AND APPOINTMENTS

PROFESSOR

S. James Adelstein '53: radiology
Shervert H. Frazier, Jr.: psychiatry
Edgar Haber: medicine
Stephen M. Krane: medicine
Toichiro Kuwabara: pathology in the department of ophthalmology
Irving M. London: medicine in Harvard University and in the Massachusetts Institute of Technology
Edwin W. Salzman: surgery
Robert E. Scully '44: pathology at Massachusetts General Hospital
Gordon F. Vawter: pathology at The Children's Hospital

ASSOCIATE PROFESSOR

Frederick W. Ackroyd: surgery at Mt. Auburn Hospital
Douglass F. Adams: radiology at Peter Bent Brigham Hospital
Ross J. Baldessarini: psychiatry
T. Berry Brazelton: pediatrics at TCH
Nancy L. R. Bucher: medicine (oncology)
Harold F. Dvorak '63: pathology
Renato O. Gazmuri: medicine at Boston City Hospital
Allan Goldblatt: pediatrics at MGH
Thomas P. Hackett: psychiatry at MGH
Zach W. Hall: neurobiology
George A. Lamb: preventive and social medicine
Marjorie J. LeMay: radiology at MGH
Edward Lowenstein: anesthesia at MGH
Luis V. Melendez: microbiology at New England Regional Primate Research Center
Daniel E. Morse: microbiology and molecular genetics
John T. Potts, Jr.: medicine
Pasko T. Rakic: neuropathology
Kogi Yoshinaga: anatomy

ASSOCIATE CLINICAL PROFESSOR

Daniel S. Bernstein: medicine
Stanley H. Eldred: psychiatry
Albert J. Kazis: dental auxiliary utilization and training
Daniel Miller: otolaryngology

ASSISTANT PROFESSOR:

Porter W. Anderson, Jr.: microbiology and molecular genetics
Joseph Avruch: medicine
Richard D. Baerg: medicine
David S. Barkley: neuropathology
James C. Beck '63: psychiatry at Cambridge Hospital
Myron L. Belfer: psychiatry at Massachusetts Mental Health Center
Alan H. Bennett: surgery at PBBH
Julien F. Biebuyck: anesthesia
Peter C. Block '64: medicine at MGH
Carl N. Brownsberger '55: psychiatry at BCH
Victoria Chan-Palay: neurobiology
William L. Chick: medicine
Cecil H. Coggins '58: medicine at MGH
Thomas L. Delbanco: medicine at Beth Israel Hospital
Martin Dym: anatomy
Leonard L. Ellman '67: medicine at MGH
Giuseppe Erba: neurology at TCH
Richard W. Erbe: pediatrics
Kenneth E. Fellows: radiology at TCH
Bernard G. Forget: pediatrics

Gerald H. Friedland: medicine at BIH
Eleonora G. Galvanek: pathology at PBBH
Lawrence M. Gettleman: prosthetic dentistry at the Harvard School of Dental Medicine
Herman K. Gold: medicine at MGH
Daniel A. Goodenough: anatomy
Reginald E. Greene: radiology at MGH
Harry J. L. Griffiths: radiology at PBBH
Joel F. Habener: medicine
John T. Herrin: pediatrics at MGH
John G. Hildebrand: neurobiology
Irvin N. Hirshfield: medicine (biochemistry)
Cyrus C. Hopkins '64: medicine at MGH
Mary C. Howell: pediatrics at MGH
Adolph M. Hutter, Jr.: medicine at MGH
Kon-Taik Khaw: pediatrics at TCH
Edward S. Kirk: medicine (physiology)
Arthur R. Kravitz '54: psychiatry at BIH
Paul J. LaRaia: medicine
Robert D. Leffert: orthopedic surgery at MGH
Michael Lesch: medicine
Myron J. Levin '64: pediatrics
Alan Leviton: neurology at TCH
Norman S. Lichtenstein: medicine at MGH
Don R. Lipsitt: psychiatry at MtA
Iolanda E. Low '53: microbiology and molecular genetics at BCH
William M. McCormack: medicine
Edward N. McIntosh '64: obstetrics and gynecology
Bernard F. Mann, Jr.: pathology at New England Deaconess Hospital
George J. Marcus: anatomy
Peter R. Maroko: medicine
Robert P. Masland, Jr.: pediatrics at TCH
Martin C. Mihm, Jr.: pathology at MGH
Pierre E. Montandon: otolaryngology at Massachusetts Eye and Ear Infirmary
Vernon D. Patch '58: psychiatry at BCH
Geraldine S. Pinkus: pathology at PBBH
Anthony J. Piro: radiation therapy at the Joint Center for Radiation Therapy
Heinz G. Remold: biological chemistry in the department of medicine
Leslie I. Rose: medicine
Chaim M. Rosenberg: psychiatry at BCH
Neil B. Ruderman: medicine
Barry S. Schifrin: obstetrics and gynecology
Ira Sherwin: neurology at BCH
Robert L. Shirley '60: obstetrics and gynecology at Boston Hospital for Women
Thomas P. Stossel '67: pediatrics
James O. Taylor: medicine at BCH
Irwin E. Thompson: obstetrics and gynecology at PBBH
Peter V. Tishler: medicine
Sigrid L. Tishler: medicine at BIH
Robert L. Trelstad '66: pathology
Stella Z. VanPraagh: pathology at TCH
Stephen F. Vatner: medicine
W. Allan Walker: pediatrics
Robert F. Watton: pediatric dentistry at TCH
William B. Weglicki: medicine
Bruce D. Weintraub '66: medicine
Alfred D. Weiss: neurology in the department of otolaryngology at MEEI
Marshall A. Wolf '63: medicine at PBBH
Liza Yessayan: neurology at TCH
Noah I. Zager: periodontology in the SDM

ASSISTANT CLINICAL PROFESSOR:

William C. Ackerly: psychiatry
George L. Bailey: medicine
Peter A. Banks: medicine
Ann B. Barnes: obstetrics and gynecology
Lawrence I. Barsh: operative dentistry
David J. Becker '55: medicine
Stuart R. Bless: medicine
Richard D. Brodie: psychology in the department of psychiatry
Henry Brown: surgery
B. Hugh Burdette: oral diagnosis
John D. Doykos, III: pediatric dentistry
James F. Durkin: orthodontics
Stanley A. Forwand: medicine
H. MacKenzie Freeman: ophthalmology
Norman I. Goldberg: prosthetic dentistry
Helen M. Herzan: psychiatry
J. Wallace McMeel: ophthalmology
Edwin S. Mehlman: endodontics
Malkah T. Notman: psychiatry
Eugene A. Petersen: pediatric dentistry
Bennett Simon: psychiatry
Richard J. Smith: orthopedic surgery
Samuel Stearns: medicine
John Vorenberg '54: psychiatry
Richard P. Zimon '62: medicine

PRINCIPAL ASSOCIATE:

James Ellingboe: psychiatry (biochemistry)
Norbett L. Mintz: psychiatry (psychology)
Edward F. Voelkel: pharmacology in the SDM

PRINCIPAL RESEARCH ASSOCIATE:

Bernard Hoop, Jr.: medicine (physics)
Mrinal K. Sanyal: obstetrics and gynecology (reproductive physiology)
Dimitri Stathakos: biological chemistry
Alap R. Subramanian: biological chemistry

LECTURER:

Leo P. Krall: medicine
Harry Levinson: psychology in the department of psychiatry
Daniel Perschonok: psychology in the department of psychiatry

Alumni Day 1972

Welcome

by Robert H. Ebert

IT has become popular to speak of the crisis in medical care in this country and a variety of solutions have been offered ranging from universal health insurance to health maintenance organizations. But, whatever organizations develop for the provision of care and no matter what the system of financing, there remains a serious problem that involves medical schools quite directly. The problem is, who will provide primary care and, if it is to be the physician, how do we educate for primary care, and how do we insure that the appropriate proportion of recent graduates are attracted to the field?

Dean Ebert

Today there is a shortage of physicians whose training and interest is directed toward primary care. I lump together general practitioners, general internists, and pediatricians in this group. Because of this, some planners have advocated the training of large numbers of physician assistants, presumably to take on the responsibility for primary care. In my view, this is a fallacious approach which can only lead to greater confusion in our medical care system. I define primary care as all care that does not require the services of surgical specialists and sub-specialists in medicine and pediatrics. It is evident that this represents most of medical care. Obviously, physician assistants cannot provide such a range of services. Physician assistants can be trained to do technical tasks and to do them very well, but they cannot substitute for the general physician.

This means that the job must be done by a physician no matter what the system and yet we have few models within the medical school. University hospitals are becoming increasingly specialized and both the student and the house officer perceive the practice of medicine as a highly specialized and fragmented profession.

The argument is often made that Harvard has a special mission and should concern itself only with the education of medical scientists, teachers, and medical specialists. This premise presupposes that other medical schools will provide the manpower for primary care. There are two fallacies in this argument. First of all, if the teachers we educate are disinterested in primary care, they will not foster the education of primary physicians in other medical schools but, instead, will replicate themselves. Second, Harvard Medical School is looked to as a model and what we do will often be imitated. If we produce nothing but specialists, the educational model will be espoused by other schools. By the same token, if we can make a conscious attempt to do something about the training of primary physicians, that too will be adopted as educational policy by other medical schools.

In my view, the greatest challenge which faces HMS during the next decade is the development of programs for the education of physicians who will be concerned with both the teaching and practice of primary care.

General Practice Is Alive and Well in Wisconsin

by Nathan S. Davis '47

MOST masters' of ceremonies begin by noting that the speaker needs no introduction especially if he is a well-known, widely published physician. As a general practice doctor from Manitowoc, Wisconsin, I do need an introduction. My background is that I have been a general practitioner for over 20 years and my only "publications" were two inclusions in the JAMA's now defunct amusing incident column known as Tonics and Sedatives.

Twenty-five years ago few physicians entered general practice, but over the last five years, there has been a heartening ground swell of enthusiasm for the concept of the primary care physician.

The title varies — family physician, primary physician, and so on, but the concept is the same: a man or group knowing the patient well and offering comprehensive care. At times I have heard doctors, threatened by change, predict the new "primary physician" will be little more than a shuttle, a screener, not allowed to do anything on his own, and available only to route the patient to the proper specialist. This is not the image held by the modern family doctor, and it would certainly be tragic if this becomes the case. The emphasis upon the new specialty of Family Practice stems from a recognition that there has been a missing link in our health care system. Although I believe our system for providing care is the best in the world, there is a gap that separates the needs of many citizens from access to treatment. Filling this gap is the task of the modern, well-trained, family physician.

Of the patients we see, we treat 90-95 percent completely. The remaining 5-10 percent who need more sophisticated diagnostic studies or more extensive treatment are placed in the right hands. Even in that case the patient returns to us and his overall care stems from a happy cooperation of the family physician and the specific expert.

Recently, public and medical enthusiasm and demand resulted in the new American Board of Family Practice and departments of family practice in school after school. While these trends can only be laudatory, steps must be taken to ensure that this is not just a flash in the pan; that it is not just the "in thing" to do this year. There are many ideas as to what preparation an ideal primary physician will need; as well as many new ideas about the whole field of medical education. The two need not be antagonistic. While the concept of renewed emphasis on primary medical care is supported, those areas of the curriculum that have encouraged a student to specialize earlier, into narrower and narrower subspecialties, should be modified. While specialization can be meritorious, we must preserve the old HMS saw that it is essential "to treat the patient as a whole."

The medical school curriculum should not be tailored for family practice alone; rather, it should recognize the existence of, and approve the concept of, the family practitioner. I can understand variation in curriculum for those who plan to treat patients as contrasted to those who plan to conduct basic research, or emphasize teaching almost exclusively. However, the future family doctor should get his training in surgery from surgeons, his psychiatry from psychiatrists, and his family medicine from family physicians. In Wisconsin, we have an elective ten-week summer program following the first year of medical school whereby embryo physicians are exposed to all aspects of rural or small city medicine. If this is the direction a student chooses, after graduation he will take a rotating internship, a year of residency with emphasis on diagnosis and complete, comprehensive patient care, followed by another year in the field with a group practice or an up-to-date, motivated family practitioner. If the future practitioner plans to set up practice in a remote area where more general surgery is needed, he receives additional training in surgery.

A key ingredient in meaningful curriculum change is utilization of the general physician. In communities across the country, the generalist has acquired too much educational experience in his practice to be ignored when curricula are analyzed, especially in the midst of medical student demands for "relevance." It is heartening that important medical learning centers have begun to recognize that 20 years in a Manitowoc, Wisc. or a Deerfield, Mass. have provided physicians with keen insights into comprehensive medical care that are nearly impossible to acquire within the confines of the medical school campus. Remember, the "typical" patient-population is not on campus. The Family Practice Program in Wisconsin is a leader in promoting the idea that the experiences of a community physician should be tightly interwoven in any program for training new physicians. Who better can "tell it like it is" in the world of real practice than the primary care physician?

Recently in the JAMA there was a summary of a plan at a nearby school to train in the five years following high school, what the article termed PMD, or Doctor of Primary Medicine. These would be strictly gate men to shunt the patient to the proper specialist. Such an individual may be of use in an area short of

physicians, but I think it is a misuse of the word "doctor." To me the term "doctor" connotes a graduate degree and a recognized level of expertise. The PMD concept seems to involve little more than the more ambitious physician assistant programs which are being initiated around the country. This training belongs in the physician assistant category.

The complete family physician as I visualize him would not be omniscient, but would have training in all fields, be able to sort out the rare and exotic mysteries, but even more importantly, he would treat the vast majority of patients himself. The modern family physician would keep up with new developments through advances in medical record-keeping procedures, such as problem-oriented records; through vastly improved continuing education programs, such as those pioneered at the University of Wisconsin in Madison; and through new possibilities for computer and other technological application to everyday practice. The modern MD may well have a physician assistant or a well-trained nurse to do much of his routine. Pediatric checks, OB, obesity, hypertension checkups, dressing changes, suture removal, even house calls, and, in the more remote areas, traveling sick calls — all could be handled by the assistant under the MD's authority. But this assistant would not be a doctor or an independent practitioner by any name. The family physician would be fully prepared to continue his education and to take on more responsibility as he proved his capabilities through training and experience. He could develop special interests, standing as a physician among other physicians at school or meeting place. He could even decide to return to residency and change specialty. None of these avenues would be open to a lesser PMD type practitioner.

The doctor in a small community still holds the stature he has held traditionally and remains an integral fixture in *all* community affairs. He can contribute not only his professional skills, but can be active in local education affairs by serving in PTA and on school boards, and by teaching nurses and ancillary personnel; by serving church and service organizations and, more and more in recent years, by joining or working with the boards of directors of the local hospitals. These activities help extend the popular concept of the physician aiding the community and provide for the physician, as additional benefit, the relaxing change of pace.

Dr. Davis

I emphasize the relationship between the physician and the community because I firmly believe that in the midst of all the hue and cry about the health care crisis, when all is said and done, it is at the community level that significant and lasting changes will be made.

We are popular whipping boys for the politically ambitious, too often encouraged by physicians, who, for reasons often times obscure, prefer to scrap us entirely rather than to improve the present system of medical care delivery. I suggest we need only examine the record of shoddy workmanship and scandal connected with federal housing programs and programs for the disadvantaged and the poor. What better examples are there to illustrate that boondoggle promises in trade for votes is not the way to plug the flaws in the health care system?

Nor is the system going to be improved by baling up the political hay being harvested over the pervading question of who is to pay the bill. This question is really more important to the patient than to the doctor. I will practice no better or worse if I am paid per capita, per visit, or per week; or whether the patient, a private insurance company or the government is the agent of payment. In fact I have served in the Army on a strict salary basis, worked briefly the last two summers in an Appalachian mission hospital without any monetary gain, and practiced on the traditional fee-for-service basis. I don't feel that quality of care has been affected by any of these.

Lasting innovations in the health care system will be made at the community level with the solid assistance that has been offered traditionally by the Harvards and the Wisconsins of this country. There is so much right with American medicine and its newer concepts of improvement that we simply must overcome petty politicking by practicing the best medicine possible in each of our communities.

The Organization Man

by W. Palmer Dearing '31

It is a myth that William Whyte's "Organization Man" typifies the physician in prepaid group practice. Whyte says the organization man not only works for the Organization — he *belongs* to it as well. "They are the ones of our middle class who have left home, spiritually as well as physically, to take the vows of organization life."[1]

To be sure, the physician's spouse and family may think this description fits anyone who embraces the practice of medicine and devotion to his patients, and the physicians in prepaid group practice yield to none in their dedication to professional excellence and commitment to their patients' welfare. In fact, experience in prepaid group practice has led many physicians to conclude that this milieu enables them to practice better medicine because of the intimate daily association with colleagues selected for their professional attainments and compatibility, and because of the freedom from business procedures and economic considerations with respect to individual patients, which are part and parcel of fee-for-service practice — individual or group. Therefore, I accept the title "The Organization Man" as a complimentary one denoting the physicians who choose to practice in the medical care services delivery system of prepaid group practice.

Much emotionalism on the part of the medical profession surrounds the organization of medical care. It is true that the physician-patient relationship is a highly individual and personal one. It does not follow, however, that the physician must practice alone and exact fees on a piecework basis to maintain an ethical status. Prepaid group practice is a time-tested delivery system, the demand for which is increasing in the United States. It is perforce satisfying to physician and patient alike, and while it does not solve all the problems of medical care, it lessens many of them.

Let me review with you what prepaid group practice is and also, particularly from the standpoint of the practice of medicine, what it is not. For the practicing physician, the term "prepaid group practice" means the practice of medicine in a medical group which is the key component of an organized health services delivery system designed to provide comprehensive medical care service to a voluntarily enrolled population, and which is compensated on other than a fee-for-service basis from regular periodic premium payments by or in behalf of (by employer, for example) the enrolled population.

Group practice plans are distinguished from other providers, financers, and insurers of medical care services in that the plans and their medical groups of physicians assume responsibility for providing, and in fact do provide, comprehensive health care services to their enrolled membership. This health services system is to be distinguished from conventional and well-known health insurance offered by the Blue Cross-Blue Shield and commercial insurance companies, which pays the provider or indemnifies the insured person in whole or in part for services which he has received, but which plays no role with respect to the availability, acceptability, or quality of health services provided.

An insurance company sells protection against medical costs in the event of illness or injury. It is a financial arrangement, not a health care arrangement. Group practice prepayment plans, on the other hand, accept responsibility for organizing and delivering health care services. The arrangement is partially financial but more nearly, it is a health care arrangement. Stated in its most simple terms, an insurance company's primary undertaking is to pay claims, whereas a group practice prepayment plan's principal undertaking is to provide a capability for furnishing comprehensive health care.

Just as the group practice prepayment system differs significantly from the insurance system, it also differs from the conventional patterns of providing health care in this country. Prepaid group practice represents an organized delivery system that coordinates health care resources (physician services, hospital, and others) to provide comprehensive health services to the plans' enrolled populations.

The medical group is the key to the entire system — not only for the physicians but for the members. Without competent, diligent, responsible doctors who collaborate professionally to provide the best possible preventive, diagnostic, treatment, and restorative medical care to their patient population, all the supporting staff and educational, social and other services, even if operating in the finest facilities, are spinning their wheels. This is so whether in prepaid group practice or in a Harvard hospital teaching service.

It should be a trite truism to a Harvard Medical Alumni audience that doctors are the *sine qua non* in providing medical care. However, some recent proposals and, indeed, actions in this community would introduce social and political considerations which are totally unrelated to the teaching and practice of scientific medicine, thereby diluting and confusing those two worthy and altogether demanding objectives.

There comes to mind, for example, the announcement of a meeting on "psychosurgery" held in Amphitheater C in May, 1972. A statement accompanying the announcement proclaimed: "The fight against psychosurgery and the fight against capitalism are integrally related!"

Returning to the real world of the practice of medicine in the organized prepaid group practice setting, let me describe salient characteristics of the best known, largest, and most successful group practice plan — the Kaiser-Permanente Medical Care Program. The name does not refer to a particular organization or single legal entity. Rather, it denotes a cooperative endeavor by a number of organizations to arrange and provide health care to over 2,250,000 people in the six geographical regions in which the Program operates: Cleveland, Ohio and Denver, Colorado in addition to the West Coast and Hawaii.

The principal organizations are Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and six independent Permanente Medical Groups. The Health Plan is the link between the enrolled subscriber-member and the Permanente Medical Groups and Kaiser Foundation Hospitals, through contracts with each. The Health Plan and the Kaiser Foundation Hospitals are nonprofit organizations exempt from federal income tax; the six Permanente Medical Groups are partnerships, professional associations, or corporations whose income is, of course, subject to tax. Despite legal, ethical, and historical constraints that have shaped a Program comprised of several legally separate organizations, they are engaged in a unitary endeavor to provide high quality comprehensive medical care to their enrolled population. The whole is more than the sum of its parts.

Dr. Ernest Saward, an internist who for twenty-five years was director of the Kaiser Oregon Region Permanente Medical Group, says the following with respect to the basis of Kaiser's successful operation and growth:

> The program, self-sustaining, must be conducted in the paramount interest of the membership . . . Five basic principles are:
>
> Prepayment, including community rating, spreads the cost over the covered population and provides stable revenue for organizing appropriate services.
>
> Practice by an autonomous, self-governing, full-time medical group, paid by capitation or another budgeted method and not on a fee-for-service basis.
>
> (Incidentally, "capitation" is verbal shorthand for "per capita" — which in this context means periodic payment of an agreed sum for each person enrolled, rather than a fee-for-service rendered.)
>
> Practice in a medical center by a hospital-based group. Satellite clinics may serve outlying neighborhoods.
>
> Voluntary enrollment. We do not accept members, unless there is at least a dual choice with the alternate being either an indemnity insurance plan or Blue Cross-Blue Shield. (In other words, no employer or union business agent can blanket his membership into the Kaiser-Permanente Medical Program; each member has a choice between Kaiser and a meaningful alternative health benefits system.)
>
> Comprehensive benefits, including preventive care.
>
> Capitation payment is a reversal of the conventional economics of medical care. Physicians and hospitals are usually paid only for care and treatment of illness on a piecework basis. In the Kaiser Foundation program, physicians and hospitals are paid by capitation for the services they contract to render. Comprehensive coverage is a necessity because it permits planning for the health needs of the population and the most appropriate use of the budgeted dollars. If only hospitalization is insured, the prospect of hospitalization is increased.

Drawing from this brief description of the organization and principles of what is prepaid group practice in the Kaiser-Permanente Medical Care Program, I would invite your attention to four frequently expressed misconceptions of what it is not.

First, it is not "corporate practice" in either the legal or historical sense, in spite of the American Medical Association's current campaign to so label it in a pejorative sense. The independent partnerships and other organizations of physicians associating voluntarily and contracting with a nonprofit Health Plan to provide medical care to a voluntarily enrolled population bear no resemblance to the iniquitous arrangements imposed by lumber, mining, and other industries on captive physicians in isolated communities at the turn of the century.

Second, it is not "doctors on salary." The physicians' organizations are created and controlled by them, including the services and compensation therefor, terms of which are negotiated and periodically renegotiated with the Health Plan. To be sure, new physician recruits are employed on salary for a probationary period, but of the 1,000-odd physicians who comprise the Northern California Permanente Medical Group, 677 are partners according to a recent report.

Third, it does not serve "captive patients." The enrolled population select the plan in preference to at least one or more optional plans of the Blue Cross-Blue Shield or commercial insurance type. Opportunity to reaffirm or change the choice of option is afforded periodically, and the result has been a steady trend from insurance to prepaid group practice.

Fourth, it is not primarily an economic, cost control system, although cost experience is favorable to the patients in terms of out-of-pocket expense, to the community in reduced requirements for hospital facilities, and to the physicians in economies of scale through pooled use of supporting personnel and laboratory, medical records, and business office services. Reputation for professional excellence is a key consideration in attracting and retaining both patients and physician staff. The medical group is organized by clinical departments, and the chiefs are important in the delivery, quality, and cost of care.

Concern is sometimes expressed

Dr. Dearing

lest the physicians' economic stake in the services provided under a capitation system, in which the rate of compensation is fixed for a period of time such as a year, may motivate them to discourage use of services and prescribe less than optimum treatment and procedures. Speaking to this point before a Senate Committee last month, Dr. John Smillie, Secretary of the Permanente Medical Group serving Kaiser's Northern California Region, said:

> When I was hired by Dr. Fitzgibbon 24 years ago, his initial words to me were that poor quality of care in our enterprise is the most expensive item we can provide. On the other hand, good quality of care is the least expensive. The reason for this, I believe, is the contractual responsibility that a health plan assumes and passes on to us through the contract with us. We must provide all medically necessary care. If we fail to do this, there are many "expensive" things that can happen.[2]

Let me conclude with some observations, including a caveat, on prepaid group practice and national policy. The burgeoning national interest in this method of delivering medical care stems from advantages seen for physicians, consumer-members, and the community.

For physicians, it provides a stimulating professional environment of the sort they enjoyed in medical school and graduate training, with free collaboration and consultation focused on the solution of medical problems and free from direct economic considerations. It offers a team of colleagues with pooled skill and equipment, rotation for weekends, vacations, and study. The doctor, even the young doctor just starting practice, can be surrounded by a group of well-trained individuals, all of whom want to see each other succeed.

For the subscriber, it provides an answer to every individual's first concern with his own medical arrangements — an available doctor for medical emergencies who has been selected by his colleagues for his skill, responsibility, and compatibility, and who is subject to their professional discipline and enjoys their professional support. Furthermore, it offers him care from a single medical organization which has an economic as well as professional interest in keeping him well rather than merely caring for him when he is ill.

For society, group practice prepayment provides economies and conveniences for physician and patient alike through improved organization of medical services. It offers a remedy for the wastage of medical skills that is fostered by unorganized specialization and limited insurance programs that cover only hospitalized illness.

These qualitative attributes are reinforced by consistent, quantitative, favorable cost and use experience of group practice plans, demonstrated nationally in serving the federal employee population, who, numbering more than eight million, constitute a fair cross section sample of the U.S. population — blue collar, rural, industrial, clerical, professional, executive. Some 380,000 of these or 4.6 percent are enrolled in group practice plans, including Harvard Community Health Plan. The figure would be much higher if prepaid group practice were more widely available; penetration of the federal population in the service areas of established plans grew from 13.1 percent in 1960 to 16.3 percent in 1969.

The use of services by the federal group practice plan population was the spark that lighted the national interest in Health Maintenance Organizations (HMO), the new term invented by the present national Administration to "purify" the prepaid group practice image. The federal employee group practice plan population consistently has about one-half the rate of hospital admissions and uses about half the days of hospitalization as the federal Blue Cross-Blue Shield population. In 1968 it had less than half the rate of surgical procedures — 31 per thousand as compared with 73 per thousand for the four million Blue Shield subscribers. Group practice plan rates for specific procedures range from one-half for appendectomy and female surgery down to one-quarter for tonsillectomy.

In searching for explanations for these substantial differences, the

systematization of the fragmented medical care industry, placing the physician in rational and economic relation to its other components, comes strongly to mind. The accomplishments of the Harvard Community Health Plan in integrating hospital service for its members in four hospitals (Beth Israel, Peter Bent Brigham, Women's, Children's) with joint staff appointments and reciprocity for medical records between — of all things, Beth Israel and Peter Bent Brigham — shows that miracles can happen in organizing provision of medical care.

These dramatic differences have motivated public leaders and politicians, concerned about the medical care crisis, to join enlightened health professional and consumer groups in a campaign to develop prepaid group practice at a much faster rate than past *laissez faire* has expanded it. Industry, insurance, the financial community, as well as the health community, are being encouraged to get into the game of promoting and creating HMO's.

And therein lies the caveat. Some see the potential for economies of prepaid group practice as a chance to get a share of the easy savings. Government funds for promotion and development of HMO's attract entrepreneurs and would-be consultants, by the letterhead.

We physicians should welcome and participate in the drive to create better organization of the medical care system in which we practice. As a matter of fact, we alone — not hospitals, not medical schools, not government, not consumers, not managers, not insurers — are the only ones who can make sure that it is a medical care system, not just a business.

References

1. Whyte, William H., Jr.; *The Organization Man;* Anchor Books Edition; Doubleday and Company, Garden City, New York; 1957; p. 3.
2. Smillie, John G., M.D.; Hearings, Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce, U.S. House of Representatives, April 12, 1972.

The Way It Is Today

by John D. Stoeckle '47 and Patricia Challender Come '72

JDS: Our return to HMS for a reunion necessarily evokes comparisons between what it was like to get an education at Harvard when we were here and what it is like today. We all have a firm grasp on our own past student experience here, even though time has perhaps dulled and erased the psychic pains of it. Although we also have a secure hold on our present lives, we have little information about education at HMS in 1972 that is not second hand or blurred by our distance from today's experience. That is true even for those of us who work here. To enrich your comparisons and musings about the School then and now, we want to bring you a first hand account of HMS education. To do this we asked Pat Come '72 to share with us the results of a survey of her class that she recently conducted and her commentary about it. In asking Pat we are following Osler's dictum on learning about illness from patients; in this instance, learning about education from students who have just experienced it.

Before we question Pat, I would like to point out that her survey does not claim to be statistically precise. It is one account of reality. During the last, final weeks at HMS, 90 students gave their collective sentiments about the curriculum, the faculty, their careers, the school pressures, and its influence on their personal lives. Looking back, imagine being asked what you thought of HMS education? This kind of consumer interest is a sign of modern times just as we now ask patients about their satisfaction with care.

Now Pat, tell us about the curriculum. There are some people who argue that there really has not been a curriculum change. The only change they see is that students have more free time, which is due to the more abbreviated basic science courses that are now taught collectively. But, if students have more free time, what are they doing with it?

PCC: After the required one and a half years of basic science and ten months of required clinical elec-

tives, approximately a year and a half was left for elective experience. Students used their elective time quite variably and I would like to mention five general areas.

The first area is additional basic scienc. Approximately 40 percent of the class took more basic science electives before entering the clinic — some by interest, some in hopes of making up deficiencies in the core curriculum before taking national boards or entering the clinic, and some simply because of a lack of space in clinical electives.

Some returned to basic science electives after their required clinical courses, and found that these electives actually became more meaningful with the background of clinical experience.

The second general area is more clinical electives. Many students filled their elective time with subspecialty electives at the Harvard hospitals. Some even combined learning with travel, taking, for example, OB-GYN in California or two months of liver disease with Sheila Sherlock in England. My husband and I spent several months in new student elective offerings at the National Institutes of Health in Bethesda.

The third general area is that of research. Many students took part in research projects, lasting anywhere from one month to a year and a half. Approximately five percent of our class took a full year off for research and have decided to postpone graduation until 1973.

The fourth area is that of additional degrees. Three students, having spent a year at the Kennedy School of Government, will receive Masters in Public Policy. Five students, having studied at the Harvard School of Public Health for a year, will be receiving a Masters of Public Health. Several of these students will be receiving their M.D.'s with our class; the rest have decided to graduate in 1973.

The fifth area might be termed special experiences. At least one third of our class have participated in community medical programs such as local health care clinics, working during their free time and clinical electives.

Drs. Stoeckle and Come

Students have also had interesting experiences abroad. Several students participated in rural medicine programs in Guatemala and Colombia, while others worked in a kibbutz in Israel or spent several months studying the health care system in Yugoslavia. Most recently, one HMS senior was hired for three weeks to analyze an aspect of the medical care system of Dominica, a British Commonwealth island in the Antilles.

JDS: *How have the students felt about the curriculum change?*

PCC: Although there were individual gripes, most felt that the basic science electives were good preparation for clinical training and that the breadth of the Harvard teaching hospitals allowed for excellent exposure in the clinical years. The elective time was considered by most to represent the best part of their medical education.

JDS: *Such a question is bound to touch on their expectations of the faculty, both those that have been fulfilled, those that were not, and those that realistically can never be met. I suppose all faculty-student encounters are changed today and bound to be conflicted. But tell us how the students characterize the faculty?*

PCC: For the most part, students found the faculty quite approachable and many, particularly those who spent several elective or research months with a particular faculty member, felt that they had made some strong friendships. On the other hand, a large number of the respondents were critical of the faculty in general. The following quotations represent the way many students characterized the faculty:

"Politics and career oriented, not people oriented."

"Little consideration of the patient as a person."

"Humorless, narrow."

"Competitive, subtly hostile, aggressive, egotistical, insensitive."

"Practice hyper-oneupmanship."

"High pressure 24-hour a day physicians who show little care for their families."

"As visits, they attempt to humiliate the students, rather than teach."

"Complacent about the delivery of medical care."

"Concern with publishing above all else."

The Harvard Medical School faculty represents a skewed population. Certainly it is not representative of the average American physician. Faculty members, as far as I

can tell, have been chosen in large part for their prowess in the area of research. To their research abilities and interests, there have been added the responsibilities of teaching, patient care, and administration. It seems absurd to think that any one human being having responsibility in four such important and time-consuming areas, can do justice to more than one or perhaps two of them. In an institution in which research and publishing are such important considerations in faculty promotions, teaching and patient care fall by the wayside as the faculty struggle for tenured positions and academic recognition.

Many students feel as I do that what HMS needs on its faculty are more teachers and more physicians whose primary concern is patient care. To accomplish this, the Medical School would have to re-order its priorities and recognize first, that the worth of a physician in the training of young doctors is not measured by research accomplishments alone, and second, that the needs of both medical students and patients should receive more consideration than they do at the present time.

JDS: *Another theme of the questionnaire had to do with the kinds of careers that students think about when they enter and what they do with them while they are here. In this area, there are three questions. First, remembering what Nate Davis said about the advantages of a generalist career, how does the class divide itself between generalists and specialists?*

PCC: Approximately half of our class is headed toward a generalist career such as internal medicine, pediatrics, and family medicine, while the remainder have more specialization in mind with ultimate careers in academic branches of medicine, surgery, psychiatry, or public health administration.

JDS: *Second, it is sometimes said that school doesn't really count, doesn't change people, but did four years at HMS make students change their career choice?*

PCC: Forty percent of our class are embarking on the same general careers that they had planned when they entered HMS. By general careers, I refer to such broad categories as internal medicine, pediatrics, surgery, psychiatry, public health, and research. Of note therefore, is that 60 percent changed their minds during medical school and have decided to pursue entirely different careers.

JDS: *And the third question, is there any uncertainty, any doubt, at this stage, about the decision to become a doctor?*

PCC: Yes, there is. Ten percent of those who responded would not have chosen to go into medicine again, 66 percent said definitely yes, 20 percent probably yes, and four percent were more uncertain.

JDS: *Now, the fourth theme of your questionnaire concerned what we might call the pressures or special ambience of HMS. How did the students view the major values of the School?*

PCC: Of those responding, 75 percent felt that there had been pressures at HMS to mold them into specific types of medical school graduates, namely, pressures for them to become researchers and specialists working in academic centers. Many of my fellow students were quite bitter about the pressures they have felt and I would like to share with you some of their answers to the question, "Into what type of physician, if any, has Harvard attempted to mold you?"

> "An uptight and unhappy one."
>
> "To be a leader in medicine. There's a great deal of pressure not to be *just* a practicing physician."
>
> "The push from the top is definitely into research. The attitude is that the best students go into research, and we all want to be at least good students."
>
> "I believe that if I had done some research my chances for an excellent internship would have been greater."
>
> "Someone who is ashamed not to know an answer."
>
> "Aggressive, impolite, petty, disrespectful, immature."
>
> "A doctor who knows more about less."
>
> "One concerned with always being right, sometimes to the exclusion of intellectual honesty."

"An academic, high-achieving, university-hospital-based, polished liberal, professor-to-be in 20 years."

"There's a strong academic-research bias. All other career types have been discouraged."

"Scorn for local M.D.'s"

"Overtrained, overspecialized, and overly academic."

"One starts to feel that, unless he strives to remain in academic medical settings, he will end up unhappy and not very useful — this is an unhealthy pressure."

Others felt that the pressures to go into research or academic medicine were not so much the result of active recruitment on the part of the faculty, but the fact that in four years, most of us have been exposed largely to only one type of physician, the researcher and academician who holds a Harvard appointment. There have been few possibilities to explore other career opportunities. An effort toward this has been made, however, in the past few years with the new emphasis on social medicine, the advent of the Family Health program in which some students have functioned as primary care physicians to two families during their third and fourth years, with the opening up of electives in outpatient medicine, and the elective offered by an HMS grad, Larry G. Seidl '61, who allows a student to work for a month in his busy office practice.

It was suggested by several in our class that alumni contact with students during Medical School should be encouraged. In this way, students could have the opportunity to develop role models other than those based on research and academics.

JDS: *Finally, Pat, could you comment on how four years at HMS affected students' personal life styles? This may give some clues as to what they will look for in medical practice organizations.*

PCC: There was a general consensus that HMS has been a narrowing experience with abandonment of many formerly enjoyed extracurricular activities and outside friendships. Two student quotations reflect well this feeling of personal sacrifice:

"I've forgotten a lot of the way I used to enjoy myself."

"Without diverse outside interests, one's attitudes change in subtle says, to the point of feeling guilty about reading a novel."

A minority of students have been able to pursue extracurricular activities more fully. For some, this was accomplished simply by becoming more efficient in response to the pressure of time commitments. For others, maintainence of outside interests required a conscientious effort in which the extracurricular occasionally took precedence over extra time at the books. This is summed up by what one student said:

"I must strive to keep activities and interests alive because otherwise medicine can become too consuming."

Perhaps this reflects the conviction of today's students that one should not have to sacrifice personal commitments and interests while pursuing an active professional life.

JDS: *Survey questionnaires are partial truths because they are likely to skim off only a small bit of subjective experience and often leave a great deal to be explained. Could you make some general comment about the students' views of their education at Harvard?*

PCC: Despite the criticisms and the feeling of some personal sacrifice, there must have been something gratifying about the HMS experience that our survey did not tap, because by far the majority of students indicated that they would again choose a medical career.

JDS: *And an education at HMS!*

Old Quarterback, New Plays

by Joseph W. Gardella, M.D.

MOMENTOUS changes have occurred at Harvard Medical School of late and there is little doubt that the School has embarked upon a new era, an era characterized by new goals, new values, and a new self-styled brand of student whose views and objectives have, to no small extent, propelled HMS into this time of change.

Perhaps the time was ripe for change and renovation at Harvard. Since 1910 there has been an extraordinary degree of uniformity in both the choice of careers and types of professional activities among our graduates. Let me document this with some interesting data.

Figure 1 depicts the distribution of career choices of physicians who have graduated from the Harvard Medical School between 1941 and 1961. These years were chosen to provide a view of a fairly recent, but established, body of graduates of significant size (3018). The data, based on replies from 85 percent of the combined classes, were obtained from the tenth through the twenty-fifth year reunion reports published between 1967 and 1971.

The point I wish to emphasize is that the percentage distribution in each of the categories has remained remarkably constant throughout the period of study, varying not more than one or two percent in any year. In fact, a similar study conducted by Dorothy Murphy, reveals a virtually identical pattern of career distribution among Harvard graduates as far back as 1910. The only exception is in the field of psychiatry which attracted six percent of Harvard graduates before 1940 and 12 percent since World War II.

Figure II shows the distribution of professional activities in the same group of graduates. While only two percent claim to be in general practice, it is noteworthy that 63 percent of the graduates are engaged primarily in practice, and a total of 86 percent are involved in patient care to some extent. The remaining 14 percent are distributed variously in teaching, research, or administration. Contrary to expectations, only two percent of the graduates are involved in full-time research. As with their choice of careers, the patterns of professional activities of Harvard graduates have remained strikingly constant since 1910.

Figure III depicts the career distribution of the 91 women who graduated from HMS between 1949 and 1959.

It is difficult to predict to what extent new patterns of career choices and professional activities will emerge in the future, but it is already evident that a substantially greater number of our recent and future graduates will enter fields akin to general practice, primary care, public health, and preventive and social medicine; or into new fields embracing comprehensive health care and public policy, particularly as it relates to medical service. Indeed, since the late 1950's, increasing numbers of students have been preparing themselves for careers in social and administrative medicine. Many are pursuing programs which combine the M.D. degree with the M.P.H. or the M.P.P. degrees. Many more students are electing courses in administration, medical care planning, medical economics, ecology, ethnology, population control, and a host of other subjects related to the social and managerial aspects of medicine.

For some time, it has been apparent that this trend in education reflects the interest and concern of contemporary students for the health and general welfare of all sectors of society. They seek to establish a more equitable distribution of medical care and health facilities; to control the economic, genetic, and en-

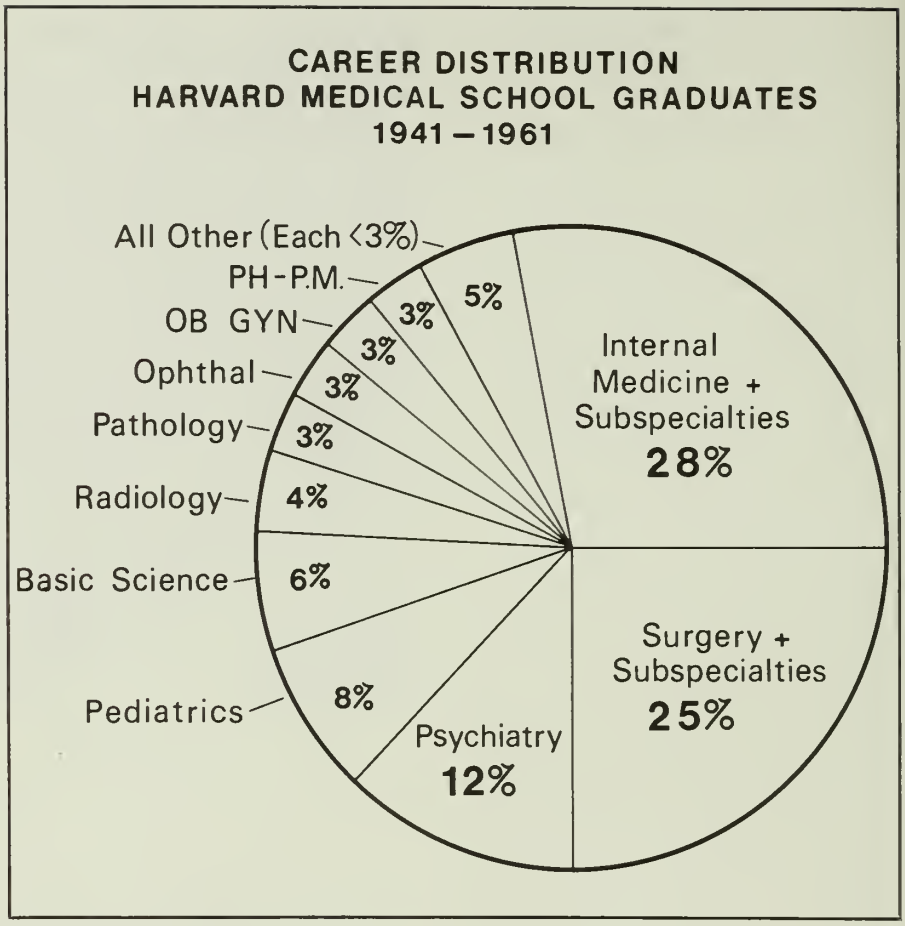
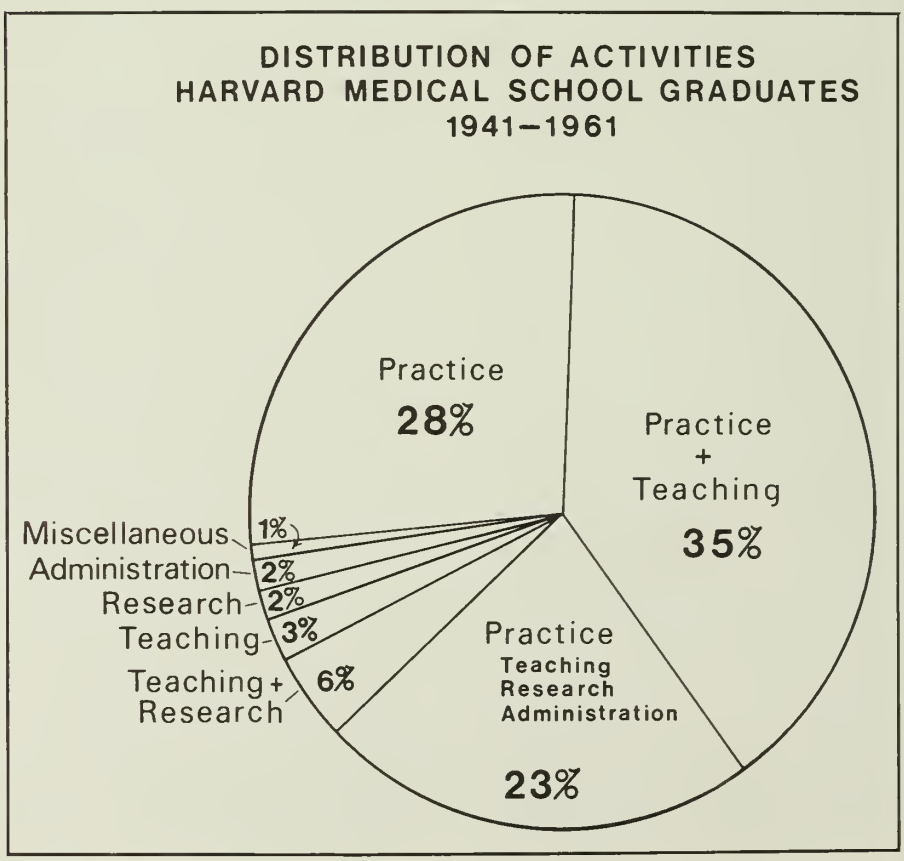


Figure I

Figure II



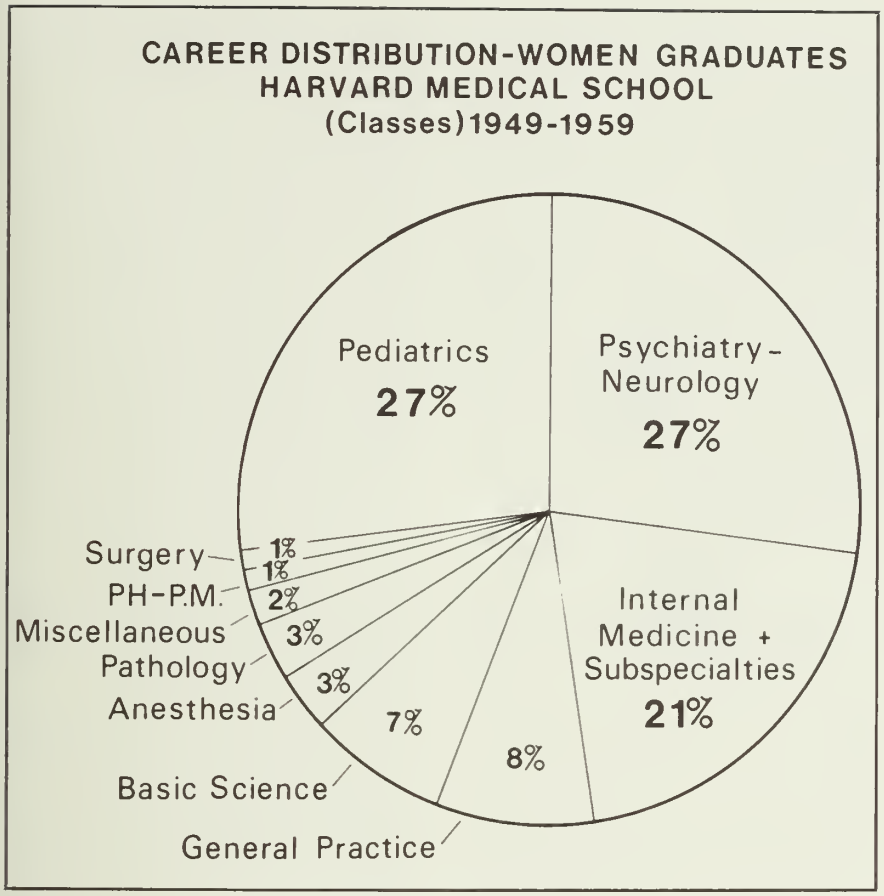


Figure III

vironmental factors influencing disease; and to promote better methods and measures of health care for all. It is in these terms that they seek to socialize medicine and hopefully, in the process, to create something preferable to "socialized medicine" if one defines the latter as the rigid and bureaucratic control of medical care by state or federal agencies.

While it is true that public pressure has alerted the School to the need for more broadly trained physicians, in my view, it is the social concern of the students which provided the initial and much of the continuing force upon the School to revise its curriculum, and to respond to the need for a new and more equitable system of health care.

Indeed, this deep and abiding social conscience of our students is but a local manifestation of the widespread student force that is trying to move this nation into an era of broad social reform and greater respect for the rights and dignity of all men. To be sure, it is an era of protestation and confrontation; and a time of irreverence for dominant social values, national shrines, and established policies; an era of frustration, conflict, unfortunate violence, and some madness. And so, for all their good intentions, it is small wonder that the students have alienated themselves from so much of society — a society that sees them as misfits, preposterously garbed, estranged, rebellious, arrogant, illmannered, self-indulgent, negativistic, and neurotic. While there are some who feel that these unsavory adjectives are richly deserved, I firmly believe that as a group, students are much maligned and unappreciated. I confess I find it surprising that, of the many who live and work with students and who presumably know them well, so few have come forth in their defense.

When, in the history of this nation, do any of you recall a more noble crusade for the abolition of war and poverty and social injustice? How much of our hostility toward the young reflects our sense of guilt that we as a society have been too long "disposed to suffer evils than to right them by abolishing the Forms to which we are accustomed?" How much does our disdain for "long hair" and "bluejeans" mask our embarrassment that they, rather than we, are the authors of their "sweet scented manuscript" for social reform? Let us grant that their style is often exasperating; their manner sometimes overbearing and overzealous; their demands for reforms impatient and impractical. But when a cause is right and just, should we not be less concerned with the manner of its expression and more attentive to the plea? Perhaps we fail to see the substance for the shadow.

I do not wish to present the students as paragons or modern prophets. They are the children of troubled times; estranged and frustrated by the order of things and in search of a broad restatement of social values. They repudiate our customs and our mores, our materialism and our technology. They even deny the relevance of our science and scorn our concepts of success. Kenneth Kenniston has said that what we as a generation accept with stoic resignation, they reject with anger and bitterness.

But not all students are angry and bitter extremists. By contemporary standards, the majority of our students are conservative, and though usually sympathetic with the radical view, they use moderate means and rational dialogue to bring about reforms, resorting at most to anonymous prose, biased argument, and timorous confrontation.

But make no mistake, they can be difficult. They have an irrepressible desire to change things, and seem compelled to alter the established order to suit their tastes; especially in matters where they are directly involved. It is not surprising, therefore, that issues such as curriculum content and design, teaching meth-

Dr. Gardella

ods, examinations, grades, evaluations, and student rights and privileges are areas of endless dialogues and frequent change. Their desire to bring about change is reinforced by their conviction that they can do better as novices whatever it is that others have been doing for years. They desire, frequently demand, to be heard and they love to play an integral role in nearly all matters of the School. They literally give the Faculty no peace until they have a hand in almost everything. They have worked their way into full membership on all but a few of the Faculty committees, and no doubt will soon find a way to get representation on all. All agree, however, that their contributions have justified their appointments for they have brought fresh views, lively interplay, and new precision to committee deliberation.

Like the rest of us, they have their hang-ups but they are also new and different. They seem overly serious and apprehensive. They tend to be suspicious of authority and accept little on faith as if for fear of counterfeit. Policies are tested for duplicity, and anxiety is provoked by circumstances beyond their control. Evaluations of any kind are threatening and they insist upon access to official files. They expect forthright appraisals of their work, but are sensitive to criticism and often quick to discredit the basis of judgment in self-defense. They seem preoccupied with momentous matters and have little concern for the social amenities. Perhaps they have had too much of the world to cope with in too short a time.

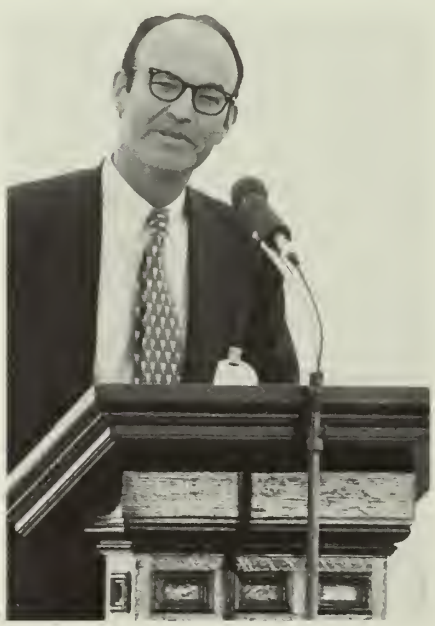
In some ways, they are immature, yet they are wise beyond their years. Their instincts and intentions are truly noble. Let me re-emphasize how much their sense of justice and their desire to serve all men directs their energies and aims. They press hard on all fronts for the advancement of minorities. They organize countless groups and much of the University's resources to serve the poor and the unattended. They oppose the intrusion of institutions and industries upon the rights and privileges of the community, and they define new dimensions of social responsibility embracing all mankind.

It is a time of unrest, complexity, and contradiction, and if you find it all confusing, that's the way it is. But it is also a time of hope, for I believe, as I hope do you, that the fate of the nation will pass into good hands.

Beginning a New Life

by Chase N. Peterson '56

Dr. Peterson



LET me comment on Dr. Come's interesting survey of student perceptions of the medical faculty. There was a study done three years ago of the attitudes that the Faculty of Arts and Sciences held toward their graduate students as compared to their undergraduate students. In terms of work production, the sheer grinding out of effort, the graduate students rated higher. It was even suggested that they were dreary. When asked who appeared to have the greater intellectual ability and promise, who had the greater curiosity, and who asked more interesting questions, 90 percent of the faculty voted for the undergraduates, even though the

graduate students had been chosen exclusively for their intellectual capacity and had the objective credentials to prove it. The undergraduates had been chosen by broader criteria. One wonders if seeking a graduate degree forces one to come to a focus finally, and abandon a carefree, luxurious, and elegant freedom of a liberal arts course. Focusing obliges both faculty and students to appear more dreary, more grinding. Both have criticized this situation, but I wonder who created it? My guess is that there lies here, a stern, necessary symbiosis in the process of learning a profession.

Mr. Kiyo Morimoto, director of the Bureau of Study Counsel, has been working with the study habits and parapsychological problems of students for many years. He had drawn attention to what could be called a "bereavement reaction." Mr. Morimoto noticed a bereavement or loss reaction when students were obliged to choose an area of life work. In this day of economic affluence, there is also an intellectual affluence; more careers are open to students than ever before. Secondary and college education exposes them to more, and their view is broader. When a person is finally obliged to focus on something, go deep enough to become useful in a special field, he becomes more aware of the many things he is denying himself.

There is a new image of symmetry in education and in the maturing, or aging process. Symmetry contrasts to what was formerly one directional or unidirectional; that is, to the notion that there is only a single direction on the road of life and training. Young people are less willing to wait for later experiences, for mature experiences, whether they are in the fourth grade, college, or graduate school. The notion of standing patiently in the apprentice position is less acceptable than it was, for obvious reasons. The future is less secure than it was. If the future is not guaranteed, few will be willing to wait patiently for something they believe will not be.

The symmetry lies in the reaction of older people, and old can be defined as anyone who is older than anyone else. Older people seem less smug, less satisfied with success, with having "arrived," with the traditional and advanced stages of life. The notion of marching through different stages of identity, giving up one to take on another, has less validity now than it did 20 years ago. The person arriving at "stage five" may be unwilling to forego the unrealized or altered satisfactions of stages four, three, or two. The rapid growth of new knowledge contributes to our desire to relearn. Similarly, the changes in our physical and social environment contribute to our unwillingness to rest on earlier learning.

We are now at a time when more people want to be partners in a richer life. The young want contact with the older stages of life. The old want renewed exposure to younger stages. Is it not possible for both to exchange experiences and learn from each other within a university community?

I see the alumni providing older faces and experiences for social and cultural contact with younger people in a way in which faculty alone will never have the time to do. If you are older, I suggest that you go off for a few months with your family and learn something you didn't know. Live in the midst of younger people; let them share your experiences and your reactions. Don't go as a mimic, don't go as a sycophant, don't go to worship a youth culture, one culture is no more worthy of worship than another. Go there to share.

Perhaps we can rediscover grandparents; the people who gave folk wisdom to their granddaughters and grandsons with a different perspective and dispassion than parents. Perhaps we are going to discover the educational role of grandparents. We are involved in a human realization movement; all people should be allowed to choose new careers, subcareers, or coordinated careers. I hope that in the appreciation of the symmetry of life, we will have less of the bereavement reaction that comes from passing through one stage without tasting it fully. The satisfaction to older people of returning to reexperience earlier stages of life, and especially those stages concerned with study, might be matched by the satisfaction their presence would give to young students.

class day

1972

Seven members of the 183rd class to graduate from Harvard Medical School received awards or prizes on Class Day for their work during the past four years. The Richard C. Cabot Prize for a paper on medical education or medical history was awarded to **Carl F. Nathan** for his paper: "Plague Prevention and Politics in Manchuria, 1910-1930." The papers, "Ribonucleic Acid Synthesis of Vesicular Stomatitis Virus. IV," and "Transcription by Standard Virus in the Presence of Defective Interfering Particles and Interferon-mediated Inhibition of Virion-Directed Transcription," won the Henry Asbury Christian Award for **Ernest K. Manders.** The Award is presented to a student who has displayed diligence and notable scholarship in his studies or research and who offers promise for the future. **Thomas A. Musliner** received the Leon Resnick Memorial Prize for excellence and accomplishment in research conducted during the period of study at HMS for three papers: "Studies on Estradiol Receptors of the Rat Uterus. Nuclear Uptake *in vitro*," "A Role for DNA in the Formation of Nuclear Estradiol-Receptor Complex in a Cell-Free System," and "Estradiol Receptors of the Rat Uterus. Interaction of the Cytoplasmic Estrogen-Receptor with DNA *in vitro*." The Rose Seegal Prize for research carried out by a medical student, the results of which have been published or accepted for publication went to **Nigel S. Paneth** for his paper, "The Role of BCG Vaccination in the Prevention of Tuberculosis in the United States." The James Tolbert Shipley Prize for research carried out by a medical student, the results of which have been accepted for publication or published was presented to **Howard B. Waitzkin** for, "Latent Functions of the Sick Role in Various Institutional Settings," published in *Social Science and Medicine*. The student who won the Massachusetts Medical Society Award for diligent work and for qualities that serve to designate him as a good physician, was **Bruce R. Leslie.** The Harvard Medical Alumni Association Award was given to **Kim Masters** in recognition of his all-round ability and well balanced personality. The Soma Weiss Award of the Harvard Medical Society was presented to **Edward J. Benz, jr.,** a third-year student, for his paper, "Defect in Messenger RNA for Human Globin Synthesis in Homozygous Beta Thalassemia."

Five members of the Harvard School of Dental Medicine, Class of 1972, received awards and prizes. The Harvard Dental Alumni Gold Medal for "all-round excellence," was presented to **Howard L. Needleman. Dr. Needleman** also won the Dr. Norman B. Nesbett Medal for "excellence in the field of dentistry." The Harvard Dental Alumni Silver Medal "for all-round scholastic excellence" was awarded to **Owen R. Burns. Stanley M. Shafer** and **Jacob B. Silversin** won the Dr. Grace Milliken Award "for the outstanding paper in the field of dental health." **Paul R. Burnett** was given the Harvard Odontological Society's Award "for the best student seminar."

Valediction

by Dean Robert H. Ebert

EACH year at this time it is my privilege to say a few parting words to the graduating class and to participate with the class in the reading of an oath. As you know, there are two oaths which I will read and some of you will prefer the ancient oath of Hippocrates despite some of its anachronisms, while others of you will choose to read the oath of Geneva which conveys in more modern terms the spirit of the Hippocratic oath. In part, this is a symbolic act which represents your acceptance of medicine as a profession just as your diplomas symbolize the University's endorsement of your qualifications as physicians. But, in another way, the oath you are about to take is very real for it signifies an expectation on the part of society that you will subscribe to a dedication of purpose that places the welfare of your patients above your own. Not all of you will achieve this degree of dedication but I believe that all of you will try, each in his or her own way.

It is popular to ascribe to each graduating class a particular kind of character, but the facts belie this attempt at classification. Every graduating class is made up of individuals of diverse backgrounds and interests; there are always substantial differences of opinion and attitudes among the members of each class. It is not surprising, therefore, that there is no unanimity of opinion in the Class of 1972. I should be distressed if there were, for you would contribute less to society if, as a group, you had neatly pigeonholed all of the problems facing medicine and the nation and had agreed unanimously on the solutions — or even worse — thought that there were no problems.

I know that some of you disagree with me and that too, is as it should be. It is quite likely that as alumni some of you will wish to see changes in both the direction and character of the School and I have no doubts that you will make your views known to me, to Perry Culver, and to our successors. I assure you we will listen. As Dean for seven years, I have learned a little about a lot of things; I no longer regard myself as a specialist in anything. In an age of specialization, it is presumptuous for the non-expert to give advice, and yet I dare to do so because I have learned two things which you may find useful no matter what careers you choose.

The first lesson I learned as Dean was to listen — to the Faculty, to students, to the alumni, to all sorts of people in the world outside the Medical School and the University. I learned that it was important to listen without prejudging; I would urge you to do the same. It is very hard to listen sometimes, perhaps the hardest task there is, but it is the only way I know to acquire understanding of other people and other points of view.

The second lesson I learned was that most people are honest about the opinions they hold and are not Machiavellian in their motivation. This is not to say that self-interest is unimportant but it is by no means the only motivating force. As you go your separate ways, I expect that there will continue to be disagreements among you, some of them quite fundamental, and I would repeat that this is healthy. I do not suggest that you agree on everything; I do urge you to be charitable toward your classmates. It is possible to disagree and still respect the motivation of another person. I hope that you will view your classmates and even the Faculty and administration in that light. Curiously enough, trust still has a place in the modern world.

The Class of '72 recites the oath.

On the Future

by Donald M. Berwick '72

A class passes quickly through Harvard Medical School; there are four years of talk about change, innovation, and new directions for the School. But, at the end, there is a feeling, not of movement, but of stasis. Harvard goes on, and discussing change in our School has had roughly the same immediacy as discussing continental drift.

But, Harvard lives in time, it occupies space, and because it uses society's resources, it is asked by a changing society to play a changing role. The world where Harvard lives has a right to ask.

If we have a sense of the direction, then we may make some predictions about where Harvard will either plan to go, or be dragged. Allow me then, three predictions.

Prediction Number One

Society will require that the Harvard Medical School and the Harvard School of Public Health merge. There is a sad chasm between preventive and social medicine on one hand, and acute and curative on the other. The burden to give the student a sense of continuity in caring for patients, the feeling that the doctor's fundamental work is to maintain health, not merely to cure disease, falls on a few eclectic teachers. We work in hospitals, subtly being taught to forget that the arrival of an ambulance signifies a failure to prevent illness as much as an opportunity to cure it.

The Medical School alone lacks the strength to overcome this division. The School of Public Health alone lacks the strength to inject awareness of preventive medicine into acute clinical settings. For these and other reasons, it is proper and inevitable that the two merge — first in curricular cooperation, then in clinical settings, and eventually into a common faculty and administration. The creation of a "Harvard School of Medicine and Public Health" will provide administrative roads to total health care training and delivery where now there are only administrative fences.

Prediction Number Two

Society will force Harvard to put health care planning to use. Harvard Medical School has developed, in the Center for Community Health and Medical Care and other areas, a laudable first cohort of health planners, with the ability and willingness to work with governments and private groups to construct coordinated, rational, health care systems. But, it has not been honest in applying this planning ability in its own backyard — to the associated hospitals. Harvard Medical School, by its silence encourages, and by its name assists, in the development of new, inpatient, acute, hospital facilities costing tens of millions of dollars to replace hospital beds we already have. Harvard Medical School has remained silent, while a major hospital, against all notions of rational regional planning, begins programs in open-heart surgery and renal transplantation within two blocks of a hospital in which both programs already exist. It does not make sense to buy redundant hospital care, or shinier hospital rooms, in a city where primary care and preventive medical efforts are plagued by want.

Hospitals in expansion are by nature autistic. They confuse hospital care with health care; hospital expansion with the improvement of health. Harvard should devise and use means to entrain that autism into coordinated regional health programs. Can't Harvard become a setting where the financial powers in private health efforts can be helped to direct their money and authority toward meeting social medical needs, instead of being bound by institutional myopia?

Prediction Number Three

Society will demand that, in its training function, Harvard recognize that we are at an historical junction of medical care and health care. The dominance of research bioscience in medicine was a needed phase in the development of our health industry. It has brought to medicine intellectual excitement and a language for clinical comparison and evaluation, but now it is in its middle age. We must add the social perspective to the scientific bases of medicine. Without quashing the pursuit of the microscopic, can we temper it? Without denying the use of laboratory medicine, can we lower its fever? Without ceasing to promote researchers, can we begin to promote clinicians? The times demand that we bend back toward macroscopic medicine, and for Harvard Medical School, this has particular meaning. It means a restoration of the lost dignity of primary patient care. It means HMS must encourage family medicine; give students regular contact with group practices, community hospitals, and local health centers with preventive and chronic care; re-establish the discipline of epidemiology in all its potential usefullness; develop training programs for allied health personnel; and have doctors, nurses, and social workers train together as they will work together. Above all, it means that Harvard Medical School must nullify the message that has come across too clearly during four years of initiation: the message that real success, a career of real value, cannot lie in primary patient care, but only in

acute and investigative medieine. That message, that bias, is malignant, and is against the interests of the patients who, in the end, judge us. If, in our faseination with the manifestations of disease, we eontinue to forget that our job, and the job of our Sehool, is to maintain health, then our patients, the best judges of their own health, will, with the anger and the firmness of the disillusioned, remind us of that faet.

These are the trends, the direetions demanded of us by a eommunity that is just learning to doubt our wisdom. Affection for Harvard Medical Sehool nurtures the hope that those who guide it will lead willingly and well in those directions. But, if we do not ehoose to lead, then we will be made to follow. There are no other choices.

Dr. Berwick

On Medical Education

by Howard S. Kirshner '72

It is only appropriate that some member of this first guinea-pig elass of the new eurrieulum address some remarks to the edueational experiment of whieh we have been a part. I would like to offer some purely personal refleetions on the new eurrieulum in partieular, and medieal edueation in general.

New curricula at Harvard and elsewhere have resulted from an inereasing recognition that medieal students could not be expeeted to master the vast body of information in even the traditional medieal fields. In addition, the proliferating soeial and behavioral seienees, inereasingly important for careers in health eare delivery, publie health, and administration, needed equal eonsideration. The Core Curriculum sought to provide students with the essential minimum of biologieal and soeial science, plus elinieal experienee, thereby ereating inereased elective time for them to pursue detailed study in areas of interest.

In analyzing the shorteomings of the new currieulum, I am struek by the realization that most of them are independent of the ehange from old to new but are largely inherent in the strueture of medical edueation. To paraphrase Hubert H. Humphrey and other Presidential eontenders in their similar statements on school busing: it is not the specifie *format* of edueation that is important, but rather *quality* edueation.

The basie seienee eore is taught largely by lecturers, known primarily for their researeh aeeomplishments or achievements in speeialized elinical areas, eaeh of whom give one or more annual leetures on topies of their speeial expertise. Teaching is a seeondary and part-time oeeupation for most of them. Many sueh instruetors have done a competent and even inspiring job presenting their material, but many seemed to laek appreeiation for the needs and interests of medieal students. There was frequent duplieation of material in the limited time available, yet large areas of medieal seience have remained untouehed. Both "too mueh and too little" edueation have thus hindered our minds.

The elinieal eurrieulum has suffered from similar failings. Faetual material is not presented in an organized way; rather, the student apprentices himself on a ward and learns about the diseases he ehanees to eneounter. Teaehing is done by interns and residents, who are of eourse very busy, and from attending physieians, who teach as a seeondary oeeupation for whieh they are not remunerated. The sueeess or failure of many elinieal eleetives depends on the teaching ability of the resident or fellow to whom the student happens to be assigned.

The fragmentation of teaehing in the Core Currieulum has proven frustrating not only to students, but to instruetors as well. Some have lamented the restrietion of subjeet matter imposed by eourse sehedules.

It is diffieult to determine just how mueh information is essential, and just whieh faets are relevant or will prove to be in the future. As Dr. George Engel has so eloquently stated, "Today's eore is tomorrow's garbage." Certainly, limits on subjeet matter must be imposed somewhere. Thomas Huxley onee asked, "If a little knowledge is dangerous, where is the man who has so mueh as to be out of danger?" Other teaehers have resented the laek of an analytieal or intelleetual approaeh to the core material and one has stated:

> Teachers have been unhappy over being foreed by outside pressures to make their teaching superfieial. . . . In teaching some of us found ourselves apologizing for oeeasionally in trodueing material that illustrated a seientifie insight rather than the tools of the trade.

Others have questioned the motivation of students and the extent to whieh they have been permitted to plan their own eourses.

Medical school faculty members have responded in various ways to these frustrations. Some have greeted

Dr. Kirshner

the new curriculum enthusiastically and have endeavored to present a true core of information. Others, despite doubts as to the wisdom of the curriculum, have tried to teach as much as they could within the core and have offered more extensive elective courses for interested students. Still other faculty members, unfortunately, have despaired of the new curriculum, have forfeited their remaining opportunity to teach, and have become self-fulfilling prophets of curricular failure.

One solution to the current crisis in medical education might be to return to the faculties of the past, made up of small groups of teachers, intimately associated with medical students and conversant with the entire curriculum. This is the ideal of a small college education. Modern medicine, however, has become too complex to permit a return to such simple educational beginnings. Fundamental to the need for curricular reform has been the necessity of providing flexibility to meet the diverse needs of students on their way to becoming practitioners, specialists, scientists, biomedical engineers, social scientists, and administrators. The crucial question facing medical education is: How can a modern medical school offer such diverse facilities and courses, and still preserve the traditional ideal of personal teaching?

I propose the meeting ground between good teaching and varied educational opportunities must come through a more active advisory system. This would involve a small group of teacher-advisors whose role in helping students should be a major part of their academic duties. These advisors should play an active part in the teaching of core material and be familiar with the elective opportunities. In the clinical years, they could offer seminars in clinical medicine to ensure that the important areas of disease are covered systematically. The advisor system would also serve as a logical extension of, and improvement on, the "multitrack" elective curricula recently instituted at Yale and Duke. These tracks could be individualized to fit each member of the class. The system would also coordinate well with plans for the reorganization of medical school departments. Departments of medicine, pediatrics, and other specialties would be replaced by departments of primary and specialty care. Advisors would function principally in the primary care division, with electives in the specialty areas.

More important, an improved advisory mechanism could help solve the problem of student autonomy and student-faculty relations. I answer the criticism that students too often make judgments for which they are inadequately prepared by saying that the student who turns to the faculty for help frequently finds as many answers as he does professors. When students make unwise choices, it is too often because they have been misguided, or not guided at all. Improved guidance would hopefully come from a smaller group of advisors, more familiar with students' needs, and how to fulfill them. Students and teachers, in Dr. George Engel's conception, should function as members of a partnership, albeit unequal partners, rather than as parent and child, where the student must either be "passive good son, or rebellious adolescent, an Oedipal Red Guard ready to overthrow an academic totem."

Training physicians is crucial to the provision of expert and well-directed medical care, and should once again be a major goal of those teachers to whom it is entrusted. As Mark Twain put it in Pudd'nhead Wilson:

> Training is everything. The peach was once a bitter almond; cauliflower is nothing but cabbage with a college education.

On Competitive Pressures

by Kim J. Masters '72

It is obvious that we have had more diversity and more division than any class in recent memory. There are many reasons for our lack of cohesiveness, beginning with differences in backgrounds and ending with differences in aspirations. Some say that we should accept our disharmony and content ourselves with the strengths born of diversity. I am not as easily persuaded and, in fact, suspect that our failure to get along may jeopardize the level of care we distribute, and more importantly, may limit the trust we have in one another and the extent to which we participate in group activities.

What happened to us is not particularly idiosyncratic, but rather a phenomenon among young people today. In part, I see it as a product of our educational system, particularly at the university and professional level. The system functions on Darwinian principles: it selects only those with outstanding academic

achievement and hardly concerns itself with emotional and social development. In addition, it is ego-centrically oriented with prizes given only for individual achievement. Attempts to encourage group interaction are often greeted with expressions of fear that this would reduce education to mediocrity and suppress individual talent. If, however, a premium was put on the accomplishments of groups and the ability of people to work together, another dimension is added to education, which need not suppress individual talent, but rather would channel it into other directions.

Competitive pressures in education are on the rise, thus requiring competitors to devote increasingly greater blocks of time to academics. In medical education, the consequences are potentially devastating. Competition for places in medical school has more than doubled in the past four years. To be accepted into medical school, a student must devote large blocks of time to his studies, especially the laboratory sciences. This necessarily robs him of time for other pursuits.

This observation is usually countered by arguing that students today have greater innate abilities than students in the past. I find this logic bankrupt. Academic performance is being measured far in excess of other qualifications. In adolescence and young adulthood, time is limited to precious few years, and if you increase the time available for academic pursuits, you subtract it from other areas. I do not mean to imply that it is solely a matter of addition or subtraction. But, as a student becomes increasingly involved with the academic, he has less desire to break away from *that* way of thinking and interacting, and tends to face situations with intellectual distance and precision, rather than setting them aside for the closeness and relative insecurity of social interactions.

If one extrapolates from competitive pressures, the end product could well be a technician who has such limited social experience that, instead of treating patients, he services them. Furthermore, we must not lose sight of those who, having made academic sacrifices for careers, have become embittered, and extract from society all they can without regard to the academic institutions or peers with whom they shared the academic experience.

Dr. Masters

This attitude is wholly unnecessary and wasteful. It could easily be dissipated by an educational system that stressed social goals and cooperation half as much as it does the competitive and academic.

The heart and soul of social development, of course, is the ability to contribute to the life of the group and find gratification in communal learning experiences. These skills could be taught in the clinical years by evaluating the performance of student teams as well as individuals.

But what has all of this to do with us? Our class has passed through the present academic system and demonstrated, according to most measurements, extraordinary abilities. Clearly, competitive life does not end with medical school, but is the grease of the academic wheel. I would argue that we, as a class, ought to devote more time to group activities.

Academic life cannot, in and of itself, be fulfilling. To be the world's expert on alpha-omega globulin need not fill up all of life. Even if we succeed in having our expertise recognized by the world, with titles after our names and voluminous articles in our bibliography, it is not enough. In the end we become technocrats in service to our technocracy — a goal which, in retrospect, would leave us feeling we had been cheated of a richer experience.

If we look at the tremendous variety of talent in this class, in every field of the arts and sciences, it is a waste not to share these talents with one another. In addition to these qualities, our class has a powerful spirit which has made an imprint on this institution that few other classes have. It would be a loss if that spirit did not continue to find expression, as it has in issues of medical education and medical care. Changes in medicine are made more by groups than by individuals and I suspect that we will have to work together if we plan to have an impact on our collective futures.

The mechanics of our reunions are left to individual initiative. We will begin with a bi-annual newsletter and try to plan for some regional reunions. Hopefully, we can use these occasions to share, not only our vocations, but also our avocations. It may prove to be one method of safeguarding ourselves against overspecialization.

Perhaps this Class Day will mark not only the launching of successful careers, but also our commencement as a group to seek the widest possible fulfillment from our shared experience.

On Protest and Affirmation

by Erik H. Erikson

When I was told the other day that members of this graduating class had requested that (in this year of all years) I give the customary address which precedes the joint affirmation called Hippocratic, I was not sure what I was expected to do: to talk around this occasion or to the point of it. It so happened that just about then I heard Dr. Tempkin of Johns Hopkins University give a lecture right here on the history of the Hippocratic Oath. After the lecture, the more professorial types in the audience converged on the speaker to engage him, no doubt, in erudite questions. A few younger men, however, cornered me. Dr. Temkin had told us that the Hippocratic Oath was introduced into this country at the request of medical students. They asked me "Why does one want to take an oath?" Bless you, I thought, here is a theme for my address. Why, indeed, do we, and when? And why and when (I would now add) do we not want to take an oath? Thus extended, I hope, the question concerns the members of the class present today with their families, and also those who are absent — some, no doubt, in sincere avoidance of this ceremonial occasion.

To take an oath obviously means to testify to a joint tradition. On certain occasions, elders like to demand such an oath (and the Hippocratic elders were refreshingly frank about this) and younger people are not at all averse to taking them. But any formula of what is worth testifying for, also delineates what one detests and what is worth protesting. What, then, is the psychological connection between that which is to be reaffirmed today, and that which was said in protest this morning?

But let me declare first why I indeed, *wanted* to come today. I am the son of a physician, as I understand are quite a number of the members of this class. But I happen to be one of those sons who resisted the overt identification with the father, and who thought he wanted to be everything *but* a physician. Yet, by a circuitous road, I settled in Vienna, where there lived one of the greatest doctors of all time, Sigmund Freud. He was the center of a widening circle of practitioners, most of them medical men and women, who shared a common fidelity of a revolutionary kind. As I know now, they had something of that original Hippocratic determination about them. For the Hippocratic Oath originally stated certain commitments that doctors of one "sect" felt they had to formulate over and beyond the legal and traditional constraints governing the medical practices of their day.

This morning, one of the speakers chosen from among you, spoke of a "lost dignity." Young Freud as a medical researcher had been devoted to an "oath," attesting to a "dignity" that some of his teachers had agreed upon. Energy being one of the dominant concepts of the day, they had sworn "to put in power this truth: No other forces than the common physical chemical ones are active within the organism. . . . One has either to find the specific way or form of their action by means of the physical mathematical method, or to assume new forces equal in dignity to the chemical physical forces inherent in matter." And this, believe it or not, was the conceptual model for that sexual energy which Freud called libido, the unperturbed study of which earned him fame, abuse, and misuse as a pansexualist. Undaunted, he always hoped that someday the particular chemical basis of libido would be found. At the same time, however, he invented a revolutionary clinical method. I have described this as a kind of nonviolent attitude toward the healer's as well as the patient's inner life, a recognition of the unconscious (instinctual and repressive) forces in the observer as well as the observed. Thus, a new clinical vision is always based on a new combination of scientific and technological ideology and therapeutic philosophy. This every period has to recover — or discover anew: for aging visions, before long, become pseudo-realities and new ones must emerged from the reaffirmation of a common dignity. As Freud concluded, "Men are strong as long as they represent a strong idea. They become impotent when they turn against it." This was said not by a moralist, but a medical psychologist.

When I came to this country 40 years ago, not a doctor, but a practitioner of Freud's method as applied to work with children, it was the Harvard Medical School that gave me my first appointment. Thus, to be asked to testify here today rounds things out for me. In the meantime, however, I have also had, during the McCarthy era, the experience of having to refuse to take an oath. A prescribed oath, as pointed out, is at its best an occasion for the free and joint reaffirmation of a strong idea which has become part of a shared identity. But, obviously, an oath can also be used to maintain what has become trite, overused or corrupt and therefore must be resisted, even at a risk. In view of these two faces of an oath, it is all the more astonishing that the Hippocratic Oath over so many centuries has served to affirm a shared philosophy which, it seems, only today is undergoing a certain "crisis of identity." Come to think of it, this may be *your* reason for inviting me here.

An oath taken at a graduation, of course, only confirms a fact. You have had your medical school experience, you *are* doctors. The title is only an outer confirmation of an inner conversion. None of you will ever *not* be a doctor. Wherever you are when, figuratively or really, the question sounds, "Is there a doctor in the house?" something in you will respond. From here on you are answerable, because what you have learned to do and to be has become part of your identity.

Let me say a few words, then, about the developmental and historical aspects of a shared identity crisis. You must permit me to do so in my own terms, exploiting this opportunity to use you as a captive audience for a lecture on the life-cycle. It will be brief, almost instant. The period of identity development, and that means also the overcoming of identity confusion, is vitally connected with the emergence of a capacity for fidelity. One develops fidelity as — in young years — one finds people and ideas, methods and practices to be faithful to or, indeed, when one refuses to believe and reaffirm what seems to have become trite and corrupt. Because of its developmental importance, I called fidelity a *virtue*, explaining that what I really meant was the ancient word, virtu — which means strength, inner force. One could once say that a bottle of brandy, left open, was losing its virtue. It means inner strength, then, rather than the mere display of shining goodness. (Parenthetically, I am somewhat less proud of this word today, because I typically overlooked the fact that it goes back to the word vir, and once meant *masculine* strength.) Fidelity, then, is a strength and a necessary one, to be firmly established before the next two stages which, "in my book," see the ascendance of the inner strengths of Love and Care. Love includes all that you love to do, and do to awaken love whether it is in your erotic life or in the intimacies of work and play. Care includes what you care for, what you care to do, and have learned to take care of. I will not now go into all the inner conflicts that make these strengths truly dynamic in each stage, and from one to the other. I will only point out, why Identity and Fidelity must precede Love and Care. It is because only a combination of identity, fidelity, and competence makes us able to be *ethical*. Now, I know, every graduation speech praises ethics; this one, in attempting to say what an oath is, must attempt to explain it. In all brevity, then: Our *moral* principles go back into childhood, and are largely unconscious and automatic guides to a not altogether healthy sense of good and evil. We also gradually learn what is *legal* and what is illegal. In youth, furthermore, we absorb much that is *ideological* in religion and politics. But only in early adulthood can we develop values which seem to be confirmed in daily practices and in concrete competency. To be ethical, means to know *why* one affirms a set of values. And there are good historical reasons for young adults today to shoulder the burden of a rigorous critique which will confirm living principles, both for their elders and for the rising generation.

WHAT does it mean, then, to confirm ethically that one is a doctor? Let me ask first, what is a patient, and answer by telling you one of my favorite stories, undoubtedly known to most of you. An old patient comes to the office and says, "Doctor, my feet hurt, I have headaches, my bowels are sluggish, my heart pounds. And you know, Doctor, I myself don't feel so good either." As always, there is a Jewish version which throws additional light on the matter. Here the patient says, "das Ganze von mir" — "the whole of me" doesn't feel so good either. In both versions, the patient complains that he has lost the connection between the various parts of him. Tell me, he seems to plead, what is wrong with all of my parts — but tell me in such a way that I myself, the whole of me, the middle of me, can feel "Yes, I understand, and I will help you help me to handle it." This, in fact, is the true meaning of the term "ego": it is the middle that holds us together.

This story, I submit, tells us a lot about what a doctor is, and what "medical" really means. As you have noticed, I feel a bit linguistic today. Medical seems to be related to medialis, middle. It is also related to meditation, because he who meditates, thinks about the center of things. And, of course, it has to do with mediation, for one mediates by stepping in between; and with remedy as that which is to restore balance. (Somehow it also has to do with meddling and mediocrity but let's not go into that.)

If I now attempt to put together what a patient and a doctor must be for each other, I can not find a better word than the one I saw used in the last *Harvard Alumni Bulletin*. It is: "identifiable." Only if the patient feels he is dealing with an identifiable, coherent person-and-method, does he become (again) identifiable to himself; and only in being such a person-and-method can the doctor remain identifiable to himself.

Seen in this light, the present identity crisis in medicine becomes painfully obvious. But you must know that you are not alone in this. Some time ago the Pope found it necessary to preach against the very term "identity crisis" as taken too seriously by young priests. He implied that true faith does not permit such a crisis. Priests, doctors, and — yes — military men, all deal with ultimate matters of life and death, and therefore depend on certain oaths for superior sanction and mutual loyalty, for delineation and for discipline. And all undergo, at this point in history, the conflict between declining and emerging ethical forces. But you, of course, daily face, with such lofty obligations, the squalor of poverty, the corruptibility of wealth and of power, the senselessness of accident, the cold tyranny of pain, the rage of inactivation, and the finite impersonality of death.

The very "role" of the doctor, however, is in jeopardy today because the doctor's image and self-image is linked with the conflicting images of various pursuits. There is, for example, the self-made man and the medical entrepreneur, the private practitioner who, as a pointed complaint has it, "makes a killing." And there is the devoted teamworker. There is the gadgeteer and computerizer, and there is the depth psychologist. There is the medical elitist in accustomed tweed and the new health populist and activist in "natural" attire. There is the specialist

Professor Erikson

who must play the parts against the middle, and there is what is now called the primary physician, who in a new era insists on being as identifiable as the general practitioner of old. And there is the promising new specialty of family doctor.

Are you suffering from a professional identity crisis, then? Not being the Pope, I cannot give categorical answers. I can answer only with a question with which I used to confront students who claimed that they were undergoing a personal identity crisis: "Are you boasting or complaining?" For let me tell you, that much of a real crisis is semi-deliberate. You can go only that far in accusing your elders of not having delivered the goods, of not having fulfilled their promises. You must feel it in your bones that in the middle of a seemingly undeserved crisis, there is no better remedy than to make it more critical, by forcing things to come to a head and to reveal their — and your — true nature. In the critical center today is the doctor's continuing mediation not only between the patient and his wayward body parts, but also the medicines that upset "himself" while relieving his symptoms; between the patient, his family, and his community; the patient and numerous specialists and their distant data banks; the patient and an increasing number of health workers and health services. The new doctor thus must translate an old person-to-person commitment into modern methods of communication.

While the identifiable doctor and his method and philosophy remain the center of all things medical, a new generation must give concerted attention to the question of what makes the various new medical techniques and politics identifiable for the patient, so that an active sense of health is fostered rather than a confusing image of fragmented processes. There is no reason why a medical team should not be as identifiable to a patient as a single doctor can be if the team has only agreed on an identifiable style. Nor should the frequent change of domicile expose a patient to medical homelessness, if such a style is made communicable in the transfer of data to various settings. I know that such "advice" sounds utterly gratuitous; but the fact is that the establishment of intimate intercommunication in an expanding world of massive interaction is a universal problem today, a problem at once scientific and political.

Two final remarks on the Hippocratic Oath, truncated and pruned as it now stands. I suggest a historical attitude which remains aware of the continuity of tradition in the flux of historical change. If time would permit, one could take each sentence and interpret the principle hidden in it in the light of the historicity of its origins. And one could then translate every detail into modern conditions and see what formulas would reveal the old principle in the new details. A recourse to tradition always means to acknowledge how much some ancient people knew in their own way of what we only slowly learn to know in ours.

Secondly, and finally, let me tell you that the mere possession of an oath, if ever so debatable in detail, makes you enviable. As the problem of maintaining rather than maiming life becomes a matter of conscience for a mankind gradually recognizing its unity, there are many social as well as natural scientists, engineers, historians, and others who increasingly realize that their every technique has to be reconsidered from the point of view of a joint social responsibility toward man's physical and moral health. In all these and other fields, the experts are becoming aware of the fact that they are working with seemingly innocent forces and insights that cannot only be used for a new way of life but also for many new ways of death, and they are yearning for an oath-like formulation both manageable and understandable, that would make them again identifiable to themselves. The problem is the same anywhere, beginning with the very architecture of our immediate surroundings and reaching into all the networks of communication: how to create islands of identifiable wholeness in a sea of spreading, anonymous bigness. As mankind is spanned by joint awareness, it is more and more essential that its wholeness be reasserted in every here and now.

As physicians, you already have such a tradition, you are in the possession of new concrete, interpersonal competencies without which any affirmation and any protest are empty. Whether you wish to *take* one or the other form of the oath, you *have* it in you. We congratulate you.

HARVARD MEDICAL SCHOOL ANNOUNCES

The William O. Moseley, Jr.

Travelling Fellowships

THE BEQUEST OF JULIA M. MOSELEY MAKES AVAILABLE FELLOWSHIP FUNDS FOR GRADUATES OF THE HARVARD MEDICAL SCHOOL FOR POSTDOCTORAL STUDY IN EUROPE.

The Committee on Fellowships in the Medical School has voted that the amounts awarded for stipend and travelling expenses will be determined by the specific needs of the individual.

In considering candidates for the Moseley Travelling Fellowships, the Committee will give preference to those Harvard Medical School graduates who have—

1. **Already demonstrated their ability to make original contributions to knowledge.**
2. **Planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.**
3. **Clearly plan to devote themselves to careers in academic medicine and the medical sciences.**

Individuals who have already attained Faculty rank at Harvard or elsewhere will not ordinarily be considered eligible for these awards.

There is no specific due date for the receipt of applications or for the beginning date of Awards except that the Committee requests that applications not be submitted more than 18 months in advance of the requested beginning date. The Committee will meet once a year in January to review all applications on file. Applicants will be notified of the decision of the Committee by January 31. The Committee may request candidates to present themselves for personal interviews.

Application forms may be obtained from, and completed applications should be returned to:

Secretary, Committee on Fellowships in the Medical School
Harvard Medical School
25 Shattuck Street, Boston, Massachusetts 02115

REUNIONS

1922

The Harvard Medical School Class of 1922 had its 50th reunion on Friday, June 2, 1972. Twenty-one members attended.

We first met in the Quadrangle of the Medical School and listened to the morning program, after which a photograph of the class was taken. We had luncheon at the tent in the Quadrangle, but before the luncheon, members scattered and it was hard to find classmates you wanted to see.

Friday evening we had cocktails and dinner at the Harvard Club with our 21 members and 19 wives. Dean and Mrs. Ebert had dinner with us and the Dean spoke briefly about the Medical School. Myles Standish showed some fine photographs he and his wife had taken on a trip to New Zealand. They went by ship and returned by plane.

Dr. Caner reported on what he had learned from reading the literature against fluoridation, that has made him feel opposed to it. However, his classmates did not seem to be concerned, and there was no discussion.

On Saturday, we had a fine luncheon at the Countway Library. Slides of how we looked when we entered Medical School were shown and there was group singing of the songs that were current when we were young.

G. Colket Caner

1922

1927

The general consensus was that the 45th reunion of HMS '27 was a great success. Though it rained just before and after Alumni and Class day, the weather on those two days was superb, and showed off New England at its best. Of a possible 83, 29 members of the class, 20 with wives, attended one or more of the functions. All were impressed by the number who came from outside New England. Bill Heeks made the long trek from Key West, Florida. Fletch Hall and George Houck came from California, Ted Hyde from Oregon, Frank Miller from Kansas, Al Mahan from Ohio, Jack Gray from Pennsylvania, and Louie George from New York.

On Alumni Day, the morning exercises and noon luncheon in the Quadrangle provided an opportunity for renewing old friendships and being brought up to date regarding Medical School thinking and activities. Good conversation was continued at the dinner held that evening at the Down Town Club on the 33rd floor of the State Street Bank Building. The height of the building and the lovely evening combined to afford a beautiful view of Boston and the harbor with a changing scene as day turned to night and the lights of the city came on. We were pleased to have as our guests, the director of alumni relations, Perry and Mrs. Culver. Appreciation was expressed to Bill Marlow, Dick Chute, and Charlie Kickham for the fine job that they had done in cooperating with the Alumni Office in making arrangements. Lang Parsons, *raconteur par excellence,* was in rare form as an after dinner speaker, and his stories contributed greatly to an enjoyable and relaxed evening.

We gathered again shortly after noon on Saturday at the most attractive home of the Marlows in Brookline, whose hospitality was greatly appreciated. We were pleased to have our honorary classmate, Dorothy Murphy, join us for the social hour and luncheon. Here again, an

informal, relaxed feeling prevailed amid much good talk regarding family and friends, as well as discussions of trends in medical practice, past, present, and particularly future. The 45th reunion has come and gone, and all too soon the 50th will be here.

ALEXANDER MARBLE

1932

Under the influence of brilliant sunshine and balmy temperatures, 47 members of HMS '32, accompanied by 40 wives, signed in at Building A on the morning of June 2nd. The Alumni Day exercises, followed by a leisurely luncheon in the Quadrangle, were thoroughly enjoyed. The free afternoon provided a fine opportunity to renew acquaintances and visit with old friends from other classes.

On Friday evening, we traveled to the Marriott in West Newton for cocktails and dinner, where we were delighted to have Elizabeth Houghton join us. For the first time, our permanent class president, Frank Cutts was unable to attend, as he was convalescing from injuries sustained in a recent motor vehicle accident. We learned, however, that he is recovering nicely, and in his absence, vice president, John Ham, performed nobly.

On Saturday, we traveled even farther west to the lovely estate of Margaret and Carl Walter in Holliston where a delightful afternoon of visiting was capped by a superb clambake. Happily, Dorothy Murphy, who is in such demand at reunion time, was able to be with us for these festivities.

Both the sunny skies and faces of the class members and wives made this one of our better reunions and will provide pleasant memories as we now settle down to await our 45th.

GEORGE F. WILKINS

1937

This reunion was truly an event. It started with a stimulating program on a sparkling, bright morning in the Quadrangle, and gave us something to talk about during the rest of the weekend. After the traditional luncheon our reunion was transferred to Martha's Vineyard. The decision to go out of town for the weekend turned out to be a great success. Perry Culver's staff in the Alumni Office arranged for a charming place, the Harborside Inn at Edgartown. It provided a beautiful, private spot overlooking the harbor. The weather was so perfect that we could make the most of it.

Our number was small, about 43, but we came from as far as Florida and Hawaii. After a fine start with cocktails in the Frothinghams' room, we ate a good seafood dinner the first night, and roast beef the second. There were all the jokes and songs of 35 years ago and a re-reading of the ageless ballad "Allen Street" by Lou Thomas. During the day we explored the Island by bicycle and car, played golf, and swam in the pool.

We were all so enthusiastic about this kind of reunion for the 35th, we hope we will have a better turnout for the 40th.

ROBERT E. BROWNLEE
JOSEPH R. FROTHINGHAM

1942

The 30th Reunion always represents a slight trough after the high-point of the 25th reunion. A solid core of classmates managed to reappear from all sections of the country; reminiscences and recollections swirled around through the three major activities.

Alumni Day had the usual spectacular weather and the standard luncheon fare served in the Quadrangle. Max Finland, president of the Alumni Association, announced the vote to include many sections of the overall Harvard community as associated alumni eliminating the requirement for official attendance at the Medical School itself.

The dinner-dance at The Country Club on Friday evening was an enormous success with superb, abundant, solid and liquid nourishment providing the fuel for enthusiastic if substandard level of dancing. Several classmates felt that they had slightly less than total recall of the evening but this may have represented the normal process of aging rather than any specific toxic or metabolic disorder.

On Saturday, the hard core remnants of the class headed north to the Wentworth Hotel where indulgence in tennis, golf, and swimming ranged from vigorous to desultory. The day ended with a clambake on a somewhat windswept and rocky shore which served to emphasize the range of climate available in New England, even in a reunion which spanned only about 48 hours.

Progressive fragmentation through the evening into smaller and smaller groups led ultimately to the final disappearance of the Class of 1942 as a formal body until the next reunion.

In conclusion, one could summarize with a few simple facts of life. Reunions with old friends are extremely pleasant occasions. Recollections of Vanderbilt Hall, the Quadrangle, and the Harvard hospitals become more colorful and less factual as years go by. Classmates and their wives appear unusually young for their obvious chronological age. There are more and even better reunions ahead. The new Director of Alumni Relations, Perry Culver, is a man with a noble purpose who will be after all of us during the coming year for a return of the investment made in this remarkable class by the Harvard Medical School a few years ago.

WILLIAM V. MCDERMOTT, JR.

1947

1947

Over half the total membership of HMS '47 made the sentimental journey back to the 25th reunion, indicative of the strong ties established during those wartime years of our late youth behind the ramparts of Vanderbilt Hall.

Departing from tradition, the Thursday night dinner was held at the Downtown Club on top of the State Street Bank Building, a magnificent spot (once you found it) with an unbeatable panoramic view of the waterfront and inner harbor. We were fortunate to have as our guests, Dr. Finland, Dean and Mrs. Ebert, Dr. and Mrs. Carl Walter, and Dr. John Talbott. A happy occasion, even though cut short by the functions manager.

Skies cleared Friday morning for the symposium at the Quad. A pleasantly disturbing review of the ferments of the time, at the School and abroad, to which '47's own Nate Davis contributed some refreshing points drawn from family practice in his sub-suburban community.

Then Hyannis, the boat ride to Nantucket, and an incomparable weekend there with perfect weather in a superb hotel. Happiness is the White Elephant exclusively occupied by HMS '47, their wives, and offspring. Who recalls another weekend like it? To those who didn't make it this time, a promise: we'll be doing it again and when we do, don't miss it. Our eternal gratitude to Dr. Culver for a great idea, and to his staff for the detail work that made it possible.

WILLIAM J. PORELL

1952

The reunion committee, perhaps being of egotistical bent, felt that the members of the 20th reunion class wanted to see each other as much as dear old HMS and its environs. They engaged the services of the Chatham Bars Inn on Cape Cod to care for our every want and need. It seemed a happy choice.

After the traditional Alumni Day morning, lunch-under-the-tent, and beer-on-the-grass, attended by 40-odd members of the class, about 35, accompanied by assorted family, departed for Cape Cod. The New England weather surprised all by being perfect. At the Chatham Bars Inn, an excellent and informal time was had by all in spite of (my apologies) no traditional toastmasters, no clambake, and no dancing. The CBI provided certain classmates with huge living rooms in separate lodges (too palatial to be called cabins or houses) and to these, in the evenings, interested parties gravitated for informal east coast Esalen T-group get togethers. Previous *nice* guys turned out to be *really* good guys, *really* good guys became *great,* and the *great* became *fabulous.*

Days were spent golfing, (Donovan in traditional Irish green looked like the King Kong of the preying mantis set), sunning, and at tennis or sailing. Saturday afternoon, THE soft ball game took place, with Lincoln hitting the longest foul balls and the wives outdoing the husbands every time. The score added together rivalled the national debt, as did the number of errors, but the beer took the sting out of both. It was especially pleasant to see the long distance members, Kraus and Thorlakson. If they can make the 20th, *everyone* should make the 25th.

WILLIAM D. COCHRAN

1957

At the end of Alumni Day activities in the Quadrangle, members of the Class of '57 took off for Cape Cod and three perfect days at the Chatham Bars Inn. Aside from the obvious luxury of mid-August, Cape Cod weather in early June, the choice of a commercial resort avoided assigning the role of host to any classmate.

If a rank order listing of time spent in reportable activities were

made, it would be difficult to separate eating, sleeping, drinking, and talking. Close behind these would be tennis, with golf and sunbathing coming at the end. Based on enthusiasm, talking, tennis, and drinking would seem to be the leaders.

The facts are that we had superb weather at a delightful old resort with excellent accommodations and good food. Most important was the fact that friendships stood the test of time — many conversations seemed to begin where they left off 15 years ago.

The only group discussion concerned plans for our 20th reunion. All agreed they wished to attend again. Our only challenge seemed to let absent classmates know what they missed, so that they will be with us in five years. Perhaps the best way is for them to talk with those who were present, particularly classmates who travelled considerable distance.

Try one of these: Adams, Alexander, Baker, Cushing, Dickerson (California), Ditmore, Engle, Gergen (Alabama), Gilson, D. Hall (Tennessee), Hinkley, Hudnut, Lewis, Lupien, McGeown, Miller, Norton, O'Connor, Remensnyder, Rivers, Simmons, Singleton (Colorado), Sullivan, Weber, and Williams.

JOHN R. LEWIS, JR.

1962

Despite our lonely Alumni Day picture, only five brave souls, about 50 classmates, spouses, and friends gathered at the Hotel Sonesta on Friday evening for dinner, dancing, drinking, and talking. Tiggy Moellering, wife of our convalescing president, spoke for Bob, presenting both his greetings and apologies. Bill Donahue, master of ceremonies, conducted the remainder of the evening in his usual sincere, and lightly humorous manner. Highlights included awards presented to those classmates in attendance who demonstrated more than the usual success after ten years out of medical school. Awards went to Mike Oxman (research), Charlie Drummond (social responsibility), Don Gill and Arnie Feldman (culture), Graeme Hanson (women today), Bob Pyles (most loyal alumnus), and Peter Evans (hall of fame), to mention a few.

On Saturday, we commuted to the Cliff Hotel in Scituate where an enjoyable day at the beach was highlighted by a clambake, from chowder to watermelon. Fortunately, the weather was nearly perfect. The afternoon sporting event was punctuated by Bill Donahue's flying, but alas, unsuccessful football catch, which left him with double vision for a short while. Several observers, remembering back ten years, questioned whether this was a change from his usual behavior. Everything turned out well, and everyone felt our first serious reunion gathering was a successful one.

To the 24 or so classmates who never replied to correspondence, I only hope that time will mellow their behavior. To the remaining 70 who could not be here, I hope they will mark their calendars and plan to attend the 15th in 1977.

SAMUEL H. KIM

1967

Those who came were rewarded by magnificent weather and the gracious hospitality of Soon and Tad Ballantine at their lovely home on Sabrina Lake in Wellesley. In addition to the good turnout from the Boston area, some arrived from as far south as Maryland. Any balding trends were more than offset by lush beards and sideburns. The ladies were well represented thanks to Virginia Galton Bachrach, Kay Alden Finseth, Carol Wolman Holmes, and Ione Kourides. After good food and beer, spirits rose to the rusty rendition of a few second year show tunes.

The class is grateful to Bart Saxbe's mother for painting a portrait of the late Paul Schnitker, which was hung in Vanderbilt Hall as part of the reunion activities.

THOMAS P. STOSSEL

Double Devotion:

Medicine and Criminal Justice

by Edward B. Benedict '23

Dr. Benedict was president of the New England Citizens Crime Commission from 1965 to 1968, and has been honorary chairman of the Massachusetts Council on Crime and Correction since 1968. In 1972 he received the Citizen Achievement Award from MCCC "for demonstrating, as a private citizen, outstanding leadership and action in improving the Criminal Justice system."

BETWEEN 1950 and 1969, Massachusetts spent approximately 116 million dollars to arrest, prosecute, and imprison drunks. Seventy thousand drunks are arrested annually in this state and about half the inmates of our jails and county houses of correction are convicted drunks. The AMA has urged all states to consider drunkenness a sickness, not a crime.

On November 12, 1971, Governor Francis W. Sargent of Massachusetts signed a bill that abolished the crime of drunkenness. The law provides for the establishment of a system of detoxification and therapy centers for the treatment of alcoholism, and as of July 1, 1973, a policeman who picks up a drunk can deliver him to one of these clinics or take him home.

The bill was drafted in 1966 in the office of then Attorney General Elliot L. Richardson. His successor, Robert H. Quinn, accepted the task begun by Richardson, and with Representative Thomas McGee of Lynn, filed the version that, with a few amendments, became law. The bill was traced through the Legislature by a conglomerate of citizens called the Committee for the Advancement of Criminal Justice, who exhorted legislators, informed the press, and spurred others to do the same. This Committee is an affiliate of the Massachusetts Council on Crime and Correction (MCCC), a private agency housed at 3 Joy Street in the shadow of the State House.

The predecessor of the MCCC was the New England Watch and Ward Society, founded in Boston in 1878. How its members would have been chagrined by this new statutory tolerance of a transgression as old as drunkenness! From 1878 until 1940, this organization was scouring Boston in one of the most inspired wars on vice the city has ever seen. Its aim was to "keep down the weeds and give the opportunity for the flower of youth to develop." The weeds were fornication, drunkenness, pornography, drug-pushing, and numerous other less common corruptions that the Society judged were threatening

its country's fibre. At a Directors' Meeting in 1917 it was voted that "Dr. Boos (H.M.S. '01) and Dr. Cummings (also H.M.S. '01) be elected a committee to report to the next meeting of the Directors on the evils of Coca Cola."

Mr. Godfrey Lowell Cabot joined the Society in 1900. He became a member of the Board of Directors in 1908, and was elected treasurer in 1915. Until he removed himself from the Society in 1940, this formidable Yankee tackled his responsibilities with a passion that must have sent shivers through every sinner in Boston. His voice and energy were the organization's life blood.

The field general during many of Mr. Cabot's years with the Society was the Rev. J. Frank Chase. In 1916, he led a gang of his agents, most of them temporary recruits off the college campus, into a New Bedford house of prostitution. The boys sauntered in, placed some bets at the gaming tables, and let the women proposition them. When enough evidence had been gathered, the raid began. It was a bruising conquest; the Rev. Chase lost his glasses, and 50 men and women were arrested.

In the 1920's, the Society determined to stem the distressing trends in literature. In 1927 it helped ban more than 100 books, among them the works of Hemingway, Faulkner, Dreiser, Dos Passos, Conrad Aiken, Sherwood Anderson, Aldous Huxley, Sinclair Lewis, Bertrand Russell, Upton Sinclair, and H. G. Wells.

But the string of rigid Puritanism was beginning to run out. During the late 1940's the organization began a rapid transition to the New England Citizens Crime Commission. Under the leadership of executive director, Dwight P. Strong, certain "irregularities" concerning the Boston police were exposed, and the "Key Scandal" came to national attention. The organization next became the Massachusetts Council on Crime and Correction, and the concern of the agency took the subtle turn from vice to crime. The MCCC has come a long distance from the Watch and Ward Society. Its target is no longer the criminals and sinners, but the apparatus that apprehends and processes them.

An assault on criminality, the Council has concluded, must include surgery on our system of criminal justice. Today, society is at least prepared to appraise this concept and one who has pioneered in bringing this about is John J. Buckley, who left the job of MCCC state director to become Sheriff of Middlesex County, where he has instituted important steps in prison reform. The MCCC recently wrote to the Boston *Globe*, in answer to a critical citizen: "We are not convinced that caution and reform make good partners. We don't want to reform prisons cautiously. We want to reform them effectively and swiftly. We do not believe," explained Sam Tyler, MCCC State Director, "that we can only attack and solve problems when we gain the approval of the very bureaucracy we are trying to change."

Mr. Tyler's pronouncements and policies have ruffled the dispositions of officials up and down the ladder of the Department of Correction, and in both chambers of the Legislature. A veteran prison reformer often counters Mr. Tyler's assertions with the question, "How long has he been in the business?" The warden at Walpole Prison has accused him of encouraging dangerous resentments among the prisoners. Soon after he announced his resignation in November, Commissioner of Correction John J. Fitzpatrick credited the MCCC with helping him reach the decision.

"The Department of Correction has had ample time and plenty of apologists," Mr. Tyler says. "There have been enough of both."

IN addition to legislation, the Council has three objectives. One is to keep the public informed, in the hope that public education will arouse massive citizen support for reform. With help from Boston Edison, the Council produced "Light the Night," a pitch for lighted streets and yards as deterrents to crime. Prior to this we had initiated *Crime Check*, "If you see a crime, report it." These programs have been advertised as public service messages on every commercial television station in the state.

The Council has conducted forums on television, radio, and in the newspapers to present pertinent information on the system of criminal justice. Staff members have appeared on the TV programs "Point of View," "For Women Today" "Speak Out," "Confrontation," and "For Kids Today;" on the radio shows of Jerry Williams, Jim Westover, and Paul Benzaquin, on radio's "Bay State Forum," and "A Closer Look." The Council has generated editorials and feature stories in newspapers throughout the state. The messages are elaborations of a theme — the demonstrable futility of criminal justice as we have it. More than 60 percent of our prisoners go back to jail (recidivism); they are neither corrected nor deterred.

Staff members deliver the same sermons in front of school groups, Rotary Clubs, Lions, and Women's Clubs. There are more than a hundred requests for speakers a year.

Tyler calls his second objective "resource development." The idea is to spur social service organizations to tackle prison reform and crime prevention.

The Massachusetts State Federation of Women's Clubs, with 35,000 members, has been hosting speeches and workshops staged by MCCC. The Federation has formed its own Committee on Justice and Rehabilitation; the Committee works closely with MCCC. The Lowell Rotary Club, the Worcester Chamber of Commerce, the Springfield Elks, and the New Bedford-Fall River Chamber of Commerce operate "Light the Night." MCCC introduced the Polaroid Corporation to Norfolk Prison where it has assisted inmate programs with money, equipment, and loaned staff.

John Carver, a Jaycee, has begun to turn that organization on to the prison scene. Carver has initiated prison Jaycee chapters in the Bil-

lerica House of Correction and Walpole Prison. If Jayceeism seems a bit middle class for cons, listen to the comment of a Walpole lifer: "Sure, we want to be Jaycees. No one listens to cons, but they'll listen to Jaycees, even in here."

On November 30, 1971, Attorney General Quinn, Massachusetts Jaycee President Donald Hill, and an audience of Jaycees and newsmen converged on the office at 3 Joy Street for a press conference announcing a police-community relations program. Now in progress, the project was designed by MCCC, the Committee on Law Enforcement, and the Administration of Criminal Justice, this state's disburser of federal Law Enforcement Assistance Administration money.

"Dialogue is what this is about," Carver told the audience. "Communities working with, instead of against, the police." The Jaycees have accepted a prodigious assignment in effecting this conversion, and use workshops and an imaginative variety of citizen participation techniques in law enforcement.

"To maintain a visible and vocal position relative to major crime control and criminal justice reform issues," is the Council's description of its last objective. Tyler has pursued it with persistence and vigor. Officials in the Department of Correction consider his pronouncements impertinent at best. Their trouble is that people listen to him.

The disaster at Attica Prison set off reverberations that have transformed prisons in Massachusetts. A drama has developed, inlaid with confrontation and potential tragedy, and MCCC has been a participant.

The crisis began with work strikes at Walpole and Norfolk state prisons. At Norfolk, Commissioner Fitzpatrick offered an assembly of more than 300 prisoners the chance to elect committees to negotiate their grievances with the administration. On September 29, 1971, Governor Sargent appointed a citizens committee, chaired by Judge Harry J. Elam of the Boston Municipal Court, to study and advise on state prisons, and negotiations began.

At Walpole, the administration permitted the men to gather in the auditorium and present their complaints to the press and television. The prisoners invited several outsiders, among them Sam Tyler. The guards refused to admit Tyler.

On October 12, Walpole administrators sat down for ten hours with a Grievance Committee of prisoners. It was a long and bitter negotiation. Most of the prisoners' requests were denied; the administration did promise to consider the formation of a series of citizen committees to inspect and report on Walpole. On October 14, Supt. Moore and Deputy Commissioner of Correction, Joseph W. Higgins, conceded to admit the citizens' committees. Supt. Moore told the press that Sam Tyler was a radical who inspired the prison population to defiance.

On November 5, the inmates at Walpole returned to their cells for noon count, after refusing to report to work in the morning. Cell doors stayed shut. The next day, Supt. Moore began a systematic search of cells, uncovering knives, chains, and one bomb.

In another incident, 75 state policemen and the three shifts of guards arrested 36 prisoners at Norfolk on November 7. Sixteen were shipped to Walpole or Concord. The next day, MCCC came onstage. The Council had learned the names of the arrested inmates and the details of the operation. Ten of the arrested inmates were members of neogtiating committees; four were committee chairmen. The men were hauled from their cells at midnight, and several were manhandled. The press blared the story. Tyler pointed out the correlation between arrests and negotiators and suggested that the administration had "effectively, if not deliberately, abridged negotiations."

On November 10, the Council held a press conference. Judge Elam and lawyers Michael B. Keating and Max Stearn, active in litigations of prisoners' rights, were present. MCCC Deputy Director John Carver told newsmen that the Norfolk arrests were planned by the guards, who gave Commissioner Fitzpatrick a list of marked men. They threatened to stage massive sick calls if the Commissioner refused authorization to transfer the inmates alleged to be troublemakers by the guards. Fitzpatrick consented. On November 13, George M. Moore, a Norfolk guard disclosed to reporters that the Norfolk arrests were the direct result of pressure from the Guard's Union. His story confirmed Carver's. Mr. Moore resigned and moved his family after being threatened by his colleagues.

The bitter criticism aimed at the Council is misrepresentative. The night of October 12, after ten hours of requests, refusals, accusations, and counter-accusations, the inmate negotiators sat slumped in the visiting room at Walpole, waiting to go back to the cell blocks and tell the prison population what had happened. There were mutterings and savage glances at the door through which the administrators had just walked. Sam Tyler was one of 15 citizen observers who had sat through the marathon. He stood on a chair and addressed the prisoners.

"Don't be so despondent," he told them. "You got more than you think. The administration is talking to you now. Keep talking. Stay cool."

Stay cool. The message has come from various corners during the tense transition. Sam Tyler has said it repeatedly; so have other reformers who want to speed the peaceful evolution of the prison system. The Council wants swift reform, and if the critics equate impatience with radical chic, Sam Tyler and his staff will live with it.

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The New England Journal of Medicine

10 SHATTUCK STREET, BOSTON, MASSACHUSETTS 02115

Alcoholism

by Stephen M. Clement '40

alcoholism is a disease

the alcoholic is a sick person

alcoholics can be helped and are worth helping

alcoholism is a public health problem, therefore a public health responsibility

THE National Council on Alcoholism (NCA) was founded in 1944 by Mrs. Marty Mann and was incorporated in Connecticut as the National Committee for Education on Alcoholism, Inc. It was subsidized in part, during its first two years by a group from Yale. Since 1944, the NCA has tried to make the above beliefs accepted. In varying degrees, the attempts have been acknowledged officially by the American Medical Association, the American Psychiatric Association, the American Hospital Association, the American Nurses' Association, the World Health Organization, and in May, 1971, in its inexorable wisdom, the Board of Regents of the American College of Physicians.

While hairsplitting continues as to whether or not alcoholism is a disease, a symptom of a disease, or a group of diseases, it has become increasingly clear that the complexity, severity, and extent of the problem calls for dedicated, informed, and compassionate action by many diverse groups.

As the mysteries and complexities of alcoholism are unraveled, the resulting elucidation of the component entities will be even more diverse than what is presently unfolding in the areas of schizophrenia and mental deficiency. In the enigma of unraveling, it is encouraging to learn of the progress being made by the current NCA Criteria Committee, composed of a cast including Dr. Jack H. Mendelson, professor of psychiatry at Boston City Hospital. There has been vicarious intellectual satisfaction for me in being perhaps the only "ex" Ex-Officio physician member of the Criteria Committee, since I was chairman of the NCA Medical Affairs Committee when the Criteria Committee was formed. It is hoped that the *Criteria for the Diagnosis of Alcoholism* will be widely distributed inside as well as outside the health related professions, including those who deal with alcoholism in law enforcement, industry, education, and insurance. For physicians, such diagnostic criteria could be as helpful in evaluation as information on the diagnosis of heart disease, tuberculosis, and other chronic illnesses.

From its beginning, NCA has been the only national, voluntary health agency founded to combat the disease of alcoholism. NCA has expanded from a small number of autonomous affiliate councils to 120 affiliate and associate councils in 40 states. One of the early councils of NCA was the Western New York (Citizens') Committee for Education on Alcoholism, formed in 1948, of which I was the last president. During my presidency it became the Buffalo Area Council on Alcoholism. The national trend has been to encourage NCA councils to consider changing their names to NCA- ( ) Area, Inc., as do other national health agencies, including the American Heart Association and the American Cancer Society. By increasing the number and effectiveness of NCA councils, a vehicle will be provided to develop a louder national voice against alcoholism. As this becomes a reality, the NCA has continued to strive for increased representation in its Board of Directors. Under the present by-laws, each affiliate council is entitled to nominate one person from its membership for consideration. The Delegate Assembly at the annual NCA meeting then elects not less than one-third of the Board. At least another third are to be members — licensed physicians — of the American Medical Society on Alcoholism (AMSA), which is expected to become the NCA's medical component. The remaining directors of the Board are directors-at-large, elected by the Delegate Assembly. In these ways, truly national and representative Boards are built in, with one third medical (AMSA) and one third affiliate council delegates. I have been twice elected directly by the affiliates as a representative from NCA Region II (Delaware, New Jersey, New

York, and Pennsylvania) and have, of course, also been a member of AMSA. Previous to my election I had also been president of the New York State Association of Councils on Alcoholism.

NCA should be thought of not just in terms of its long-range goals, its boards, and committees with dedicated staff, but also in its day-to-day outreach through the legally recognized arms, affiliate councils and associate councils. Through these groups, NCA experience and know-how can be shared, as they seem helpful to the individual community seeking advice.

From its inception, NCA has been neither "wet" nor "dry." It has concerned itself with the abuse and misuse, rather than moderate use of beverage alcohol. With the estimated 90 to 95 million Americans who drink, there is a great need to teach the avoidance of misuse and abuse of alcohol, as well as to seek help for the estimated nine million alcoholics and those whose lives they affect adversely. In its educational outreach, though hampered by limited funds, NCA has formed various committees and component groups to pursue these concerns. NCA has had dedicated Boards of Directors and has been most fortunate in assembling a remarkable professional staff of equally enthusiastic and competent people. In 1970, the Program Goals and Priorities Study Committee published the results of an extensive study, which helped to establish the immediate NCA priorities. It is not surprising that training of members of health and other helping professions ended up in the Hertz position.

Other current NCA committees include a large Labor-Management Committee, Medical Affairs and Criteria Committee, Motor Vehicle Accidents and Alcoholism Committee, Public Information Committee, Affiliate Relations Committee, Program Services, Public Policy Committees, in addition to the more prosaic ones; Executive, Budget and Finance, and Nominating and Awards. The Office of Economic Opportunity (OEO) has renewed and expanded its contract with NCA for the fiscal year 1972-3. NCA will furnish alcoholism specialists to assist local OEO Community Action Agencies' alcoholism programs. This will help in the delivery of service to those families in poverty who suffer from the added problem of alcoholism by assisting with case management and grant application training. The OEO/NCA contract requires the NCA to develop a state planning process model which will demonstrate how the poor may be included in the planning and development of effective channels of communication between responsible state authorities and low income groups.

For many years the NCA has tried to make its citizen voice heard in the legislative and executive branches of government. Prior to 1966 there was little activity in the alcoholism field at the federal level. Small amounts of money had been awarded for alcoholism research and training through the regular National Institute of Mental Health (NIMH) granting mechanism. However, in 1966, former President Johnson ordered the establishment of the National Center for the Prevention and Treatment of Alcoholism within the NIMH, and the creation of an 18 member National Advisory Committee on Alcoholism to advise the Secretary of Health, Education, and Welfare. The original budget for the Center was three million, which increased yearly until in 1969 it reached seven million. In 1969, Senator Harold Hughes of Iowa was named chairman of a new Senate Subcommittee on Alcoholism and Narcotics. This Subcommittee conducted public hearings that generated extensive publicity which helped to persuade the Administration to elevate the Center for the Prevention and Treatment of Alcoholism to Division status. Also in 1969, NCA retained a knowledgeable and charismatic consultant in Washington, Mr. Mike Gorman, who had played a large role in the growth of the mental health movement. He went to work to accomplish similar growth for alcoholism activities. Early in 1970, Senator Hughes introduced legislation to create a National Institute on Alcohol Abuse and Alcoholism within the NIMH. President Nixon signed the bill, P.L. 91-616, the Hughes Act, into law on the last day of 1970. In these and other major national efforts the NCA and its allies have been active in testifying before congressional committees, contacting individual members of Congress, as "amicus ciruae" (friend of the court) before the Supreme and other courts. An outstanding example of NCA's involvement has been the activities of former NCA Board Chairman and Harvard Law School alumnus, the Honorable John M. Murtagh, Justice of the Supreme Court, state of New York.

Mrs. Marty Mann, Founder and Consultant, NCA

One of the concrete benefits of NCA's outreach has been the initiation of a major collaborative program with the Department of Transportation and the National Institute on Alcohol Abuse and Alcoholism, to reduce the number of deaths and injuries caused by drinking drivers. It was estimated that half of the 56,000 deaths resulting from automobile accidents in 1970 involved

drinking drivers. The NCA is deeply involved through its Committee on Motor Vehicle Accidents and Alcoholism, and its peripatetic, articulate NCA medical director, Dr. Frank A. Seixas.

NCA's *1971 Catalog of Publications on Alcoholism* includes one section of special interest to practitioners and students on medical and social services. This serves as an order form for NCA Publications Division, and recommends pamphlets, reprints, and books under the general headings of medicine, psychiatry, psychology, social work, hospital administration, and nursing. Similar help is available in many other areas, such as how to form new councils, dealing with alcoholism in industry, community services, and public education. NCA has one of the most comprehensive libraries on the subject of alcoholism at its New York office. Audio-visual material is available, with suggested recommendations for differing audiences and purposes. Continuing involvement in the production of medical educational films is an additional goal. The *Physician's Alcohol Newsletter* which may be of special interest to alumni, is published quarterly by the American Medical Society on Alcoholism, edited by Dr. Seixas.

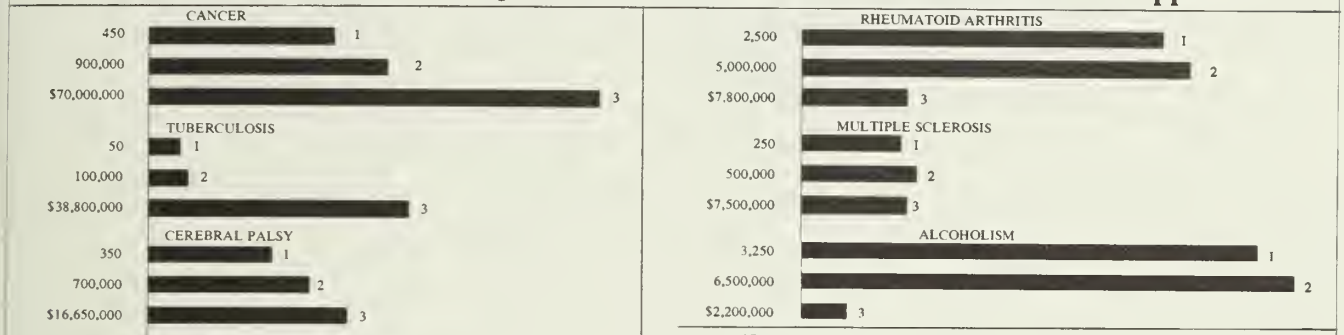
OTHER areas of NCA's thrust are special themes selected for the annual NCA Medical and Scientific Conferences. The first conference, "Professional Training on Alcoholism," was held in New York City in April, 1970. Dr. Seixas wrote: "We not only have neglected alcoholism but, by precept and example, by gesture and joke, have given the medical students an anti-education in the subject." The Student American Medical Association participated in the Conference and their final report, "Alcoholism Education in American Medical Schools," was inspired by a grant from the NCA. The Conference proceedings were published by the *Annals of the New York Academy of Sciences.* Included are descriptions of the curriculum on alcoholism of all existing facilities and medical schools that submitted them, including HMS's. Wide circulation to many non-medical groups has been helpful in extending NCA's educational goals. Various other aspects of the Conference are recorded, including an inspirational Annual Dinner Address by Senator Harold Hughes, to whom NCA gave its Gold Key Award for outstanding contributions in the field of alcoholism on a national basis. The topic selected for the Second Annual NCA Medical and Scientific Conference was even dearer to my heart: "Nature and Nurture in Alcoholism." This Conference was held at the Disneyland Hotel in Anaheim, California. In April, 1971, geneticists, behaviorists, animal and human researchers, psychiatrists and assorted others from Chile, England, Finland, Sweden, and the United States gathered. Workshops were held on nature, nurture, and nature and nurture, resulting in crossfertilization of ideas and the opportunity to confer with each other. The evidence reported in terms of defective chromosomal patterns in human blood cells, in animal and in human twin studies, helped to point the way for future research in the genetic aspects of alcoholism. The by-products of this and further investigations may help to unravel some of the complexities of the dependence, tolerance, withdrawal syndrome, and loss of control which are important characteristics of alcoholism and other addictive diseases. It has long been my personal hope that alcoholism predictive detection tests may someday be as available for mass screening as diabetic detection tests are today. Defective chromosomes may disrupt the production of enzymes which are needed for the body to handle alcohol in the normal way. Dr. Seixas put it succinctly: "Nature vs. nurture is a pseudo-problem. It is not nccessary to choose sides."

Both NCA Medical and Scientific Conferences were held immediately before the regular Annual Meeting of NCA Board and Delegate Assembly. HMS faculty was prominently represented at both conferences by two distinguished activists in the field of alcoholism, Dr. Jack H. Mendelson and Dr. Morris Chafetz. The proceedings of the "Nature and Nurture" Conference are to be published by the New York Academy of Sciences. The Third Annual NCA Medical and Scientific Conference discussed the basic theme of the neurophysiology of alcoholism.

Since Alcoholics Anonymous and NCA were founded in 1935 and 1944 respectively, there has been no official connection between the two organizations. However, many women and men in NCA have enriched both fellowships with their dedication and active participation, far above and beyond the call of duty. At one NCA Annual Meeting I had the memorable experience of shaking the hand of one of the two cofounders of AA, the late "Bill W." (Wilson). I have seen "walking miracles" in clinic and courtroom, and in devoted service to fellow alcoholics. AA has been acclaimed by some as one of the major therapeutic breakthroughs in the twentieth century, along with antibiotics and antipsychotics. Three of AA's Twelve Steps mention such concepts as "powerless over alcohol, that our lives had become unmanageable," and "came to believe that a Power greater than ourselves could restore us to sanity," and "God as we understood Him." Help has also come through the practical, living examples of AA members, who have maintained their own sobriety, "24 hours at a time," and thereby helped thousands of others to "stay away from the first drink." Obviously the benefits of contented sobriety in AA far exceed just being "off the bottle" (or "sauce") and "on the wagon."

NCA has resisted considerable pressure and temptation to extend its thrust and become primarily involved with other addictive diseases or diseases of dependency, by joining in the battle for or against "pot" or LSD. With our limited financial resources and so formidable an adversary as alcoholism, NCA has attempted to "stick to its knitting."

Comparative Positions of Major Health Problems Relative to Incidence vs. Support*



1. Est. No. per 100,000
2. Est. total cases
3. Est. 1969 total support / revenue

* *Wise Giving Bulletin, N.I.B., Inc., Spring, 1970*

There is still so much work for the "alcoholism dollar" to do, that its conservation for this purpose seems well justified. The "guestimated" number of nine million alcoholics is in marked contrast to an estimated 400,000 heroin addicts. There is still that much larger group of men, women, and children who are on a collision course with the deadliest addiction of them all: cigarette smoking. However, NCA remains in a strategic position to disseminate information about addictive diseases, without getting submerged by trying to deal with each one.

In learning about the history of NCA, there are some "living books," who were "where it was at" in the early days. In addition to the founder, Mrs. Marty Mann, the Reverend Yvelin Gardner, her devoted, dependable, assistant deputy and Harvardman is still deeply involved in NCA as its Program Service Director. Another long time NCA worker is the distinguished psychiatrist, Dr. Ruth Fox, who was the medical director of NCA for many years and is now on the board. The inimitable and witty Honorable Austin MacCormick, a former NCA president and long time treasurer, has regaled NCA gatherings with "Robert Benchly" treasurer's reports. He alleges to have had the amount of a minute, early NCA surplus tatooed on his "bird-like" chest for all the world to see, as he strolled on the sands at Easthampton.

Another one of the prime movers, very much from within and outside the NCA is past president Mr. R. Brinkly Smithers. Over many years he has given in unprecedented ways, his time, talents, and fortune in numerous known and unknown ways in the battle against alcoholism. Not one of the least of these was a recent gift of $10 million to the Roosevelt Hospital for the Smithers Alcoholism Treatment and Training Center. This was the largest single grant ever made in the field of alcoholism by any individual or agency, including the federal government.

From this new oasis of knowledge on alcoholism, interested HMS alumni are encouraged to learn about "Alcoholic Diabetes." (*Journal of the American Medical Association*, September 13, 1971, p. 1513) In a prophetic sentence Gerald B. Phillips '48 and Dr. Henry Safrit of the Roosevelt Hospital conjecture, "Furthermore, if alcohol does expose a defect in glucose metabolism in the prediabetic, then knowledge of the mechanism of the alcohol effect may reveal the basic defect in diabetes." For whatever an unrequested psychiatric opinion is worth, I have long fantasized and predicted that someday, someone will walk over the bridge between diabetes and alcoholism to collect a Nobel Prize. Why not another for HMS? The largesse of NCA's imaginative and dedicated Brinkly Smithers has helped the world of tomorrow to unfold today in many far reaching ways.

An event of great importance and good fortune for NCA was the selection of Mr. William W. Moore, Jr. as executive director to replace Mrs. Marty Mann, who had been NCA's first and only executive director. This change has allowed her more time for writing and lecturing, yet she is still available as founder-consultant. Mr. Moore brought his valuable experience from another voluntary health agency, the American Heart Association. His dedicated vision and organizational ability have added new talent and impetus to the NCA staff and board. I especially appreciate the help and encouragement from Mrs. Mann, Dr. Seixas, and Mr. Moore in writing this brief narrative of NCA.

Over the years the HMS faculty has encouraged students to learn about various aspects of alcoholism. Robert E. Fleming '30 was an early psychiatrist in the field; Dr. Raymond D. Adams, Bullard Professor of Neuropathology at Massachusetts General Hospital, Dr. Bert L. Vallee, Paul C. Cabot Professor of Biological Chemistry at Peter Bent Brigham Hospital, Dr. Jack H. Mendelson, and Dr. Morris Chafetz, among many others, have shown special interest and concern. Those of us who have had the good fortune to be HMS alumni can be grateful for its contributions in the challenging area of alcoholism. As the 1972 NCA campaign slogan puts it "Can you spare the price of a drink?" In conclusion, will you also spare a "think" and a "thank" for NCA.

CROSSFIRE

In the March / April issue, the *Bulletin* announced "A Contest for HMAB Readers." Entrants were asked to respond to two articles in that issue, "The Doctor and Social Change," by Howard Levy, M.D., and, in the editorial section, "The Radical Perspective," by Michael G. Michaelson. On the following pages are the replies to that request. We have published each entry we received; all are thought provoking.

William B. Greenough, 3d '57

It is a pleasure to see the *Harvard Medical Alumni Bulletin* publishing articles and comments that represent substantive debate over issues which are central to health care. I do not wish to enter my thoughts in a "contest to solve the problems," but do believe that further dialogue is essential if for no other reason than to clarify the semantics inherent in the rhetoric employed by Dr. Levy and Mr. Michaelson — rhetoric which I would agree is by no means empty. The word "radical" seems to means something rather different to Dr. Levy and Mr. Michaelson. I would further say that it denigrates both the thought and commitment of the authors to consider that addressing remarks to their challenge is "tilting at windmills." It is not.

It seems to me that Dr. Levy conceives the meaning of the word "radical" as marked by a considerable or extreme departure from the usual or current norm of medical care in this country. The thrust of Mr. Michaelson's remarks indicates that he views the meaning of "radical" as it is first defined in the dictionary, hearkening back to its Latin derivation "radix" or proceeding directly from the root. It is apparent that Michaelson perceives the trap of exchanging a radical elite for a medical elite, or of exchanging one organizational structure for another, or as he states it: ". . . What seems to be the natural alliance between radicals and those conservatives who share a genuine respect for the relationship between doctor and patient as well as a healthy distaste for the academic medical elite's Orwellian plans." An extension of this thought is, of course, a healthy respect for the relationship of one human being for another. To this definition of radicalism I can wholly subscribe. It does imply need for an urgent rearrangement of how we presently take care of the ill. It further insists on a rebirth of concern for the individual (the humanities of medicine) to at least the extent we have been concerned with the technology of medicine in recent years.

Dr. Levy's comments focus on a legitimate series of criticisms of existing medical institutions and their organization, but his implicit assumption that there is an inherent difference between "the people outside" struggling with those entrenched who currently are operating the medical institutions indicates he has failed to grasp the message of malaise perhaps best depicted in Solzhenitzyn's novel, *The Cancer Ward*. Unfortunately, unless this malaise is understood and unless one focuses on the reasons for the loss of concern for the welfare of individual human beings on which Michaelson focuses his remarks, the trap of simply replacing one organization or format for another, which may ultimately be equally unresponsive, yawns open.

I would like to comment specifically on several more traps that underly Dr. Levy's thoughts. I would have to reject the idea that in an ideal setting one would opt for all conceivable medical services. There are many medical services of doubtful value or of a nature destructive to individual rights and happiness. Some such services are very expensive and I would submit might be rejected by a society who took the trouble to appraise critically the gamut of medical offerings.

A more serious flaw in thinking to my mind is the notion that pouring all resources into a frontal attack on such scourges as alcoholism, drug addiction, etc., would result in saving many more lives. Data from Sweden indicates the colossal failure in a more ideal scheme of medical care in a followup of 200 alcoholic patients (*Hospital Tribune*, May 1, 1972, p. 13).

Frequently, it is the apparently totally abstruse, useless academic research that leads to effective preventive or curative measures which are less costly or discomfiting to the patient. But, the fostering of basic research in the sciences clearly is in the best interest of "the people."

A further thought that should disturb Dr. Levy is whether, since most of the medical health problems we face are self-inflicted — overnutrition leading to atherosclerosis, overdrinking to alcoholism, overindulgence in drugs, etc. — we should not consider it our obligation to divert some of the large sums with which we overindulge and try to assist the majority of the world's peoples to insure their basic rights of food, shelter, and protection from diseases that are readily and cheaply prevented or cured. It seems the entire focus on the health care debate is out of focus as it already views a privileged minority of the world's population. There is greater unrest in Asia about the maldistribution of this world's goods than in our most underprivileged groups. The first step in this path, of course, would be to begin by stopping the spending of our resources to kill Asiatics.

In that elegant movie "Hiroshima Mon Amour," there is a scene in which a mob of people are marching and shouting for peace. Two lovers are trying to reach each other across this marching throng. They are constantly being torn apart and swept

away from each other. I fear the march through institutions proposed by Dr. Levy, as based on the assumptions he voices, will do violence to the delicate and inestimably valuable elements which are present even now. I would join Mr. Michaelson in his thrust for change as he exhibits an awareness of values with which I concur and, if taken into account, will lead to substantive change rather than just a relabelling. Mr. Michaelson's and Dr. Levy's positions are perhaps closer than their articles indicate. I share with them both their concern with the failures of our current medical care and its institutions.

Erwin O. Hirsch '46

The question put by the learned editor is of course a loaded one. Who would ever want impersonal, regimented, bureaucratic medicine with distorted priorities? Who would want any of these horrible qualities in any area of human activity?

But who, on the other hand, has not at one time or another been grateful for impersonality, been willing to subject himself to regimentation as a way of achieving his own goals (by allying himself with others) and who has never delegated tasks he cannot handle to a bureaucracy? Distorted priorities result from ignorance, insensitivity, shortsightedness, poor organization, and lack of communication — not from impersonality, regimentation, and bureaucracy per se.

The virtual disappearance of plague, typhoid, smallpox, and poliomyelitus in the developed portions of the world was achieved and is being maintained on an impersonal basis by a bureaucracy which regiments those who do not understand the issues, or do not wish to participate in the solution. Who would insist on being protected against typhoid, the plague, etc. only through the personal ministrations of a physician?

The experience with mass screening for cervical cancer has shown that the public is willing and anxious to have even their most intimate private health needs met on an impersonal basis by a bureaucratic scheme which regiments the individual.

In most European cities, there are public comfort stations. In Vienna, I am told, the city also maintains public Pap smear stations, available to any woman at her convenience. I am told that for the past ten years, advanced cancer of the cervix has not occurred among Viennese women.

I don't usually like to be regimented into behavior patterns — even if they are for my own good. I know that smoking and eating rich foods are bad for me — yet I refuse to give them up. I would, however, gladly stop on my way to work to take my weekly dose of cancer and coronary prevention medicine from public dispensers, drop a stool and urine specimen into the mailbox once a year, and have my blood pressure telemetered at the same time.

I resent having to play a dependent role in the office of a motherly and smothering physician in order to obtain these services, just as I would resent being able to get pure drinking water only through developing a personal relationship with a kindly fee-for-service well owner.

On the other hand, when I am beset by misfortunes with which I cannot cope, when I suffer symptoms for which the physicians have persuaded me to seek their counsel, when nature seems to single me out to suffer more than others, I am eager to be dependent on a wise and learned individual. The strange thing is that I can't find one.

When I suffer visual disturbances, an internist may spend 1½ hours (worth $100 including lab and x-rays) and tell me to see an ophthalmologist. The latter may, after a thorough examination (worth $50) tell me that he has found nothing. But if I am lucky to have an elderly relative who tells me that I have a migraine, I can go to a migraine specialist who, for $50, can explain to me how to live with it.

If I have diarrhea and am losing weight, I must subject myself to an internist for 1½ hours and suffer the psychic and physical indiginities of a sigmoidoscopy at the cost of $150, repeat the procedure in the office of the radiologist (another $125) and may only be given expensive medicine which does not help. But if I happen to have a Pakistani friend, I may learn about sprue. If I succeed in partially restoring my health by following his advice, I can go to a gastroenterologist who, after subjecting me to scorn and (upon my pleading) to further expensive indignities, may condescend to mail me a sprue diet which is full of mistakes (it does not warn of malt coating of certain non-wheat cereal products) and which I must modify by applying above average intelligence to a long series of painful and embarrassing trials and errors.

In short, I must be my own contractor for my health and deal with a series of subcontractors, each of whom must charge me for his part of the job before he even knows whether he is willing and able to do the job and who takes no responsibility for failure.

If I were to suffer a coronary as I write this, my chances of prolonged suffering and perhaps dying before I get to the hospital are greater than they were 35 years ago. Back then, my doctor would be here within minutes and administer morphine and atropine. Today, my wife would be unable to reach him. He is either busy, providing nonservices to a migraine or sprue sufferer — or just needs his rest after having spent 60 hours of the last week in these frustrating and fruitless, even if well paid, endeavors. An ambulance may arrive eventually but the attendant would not be able to administer comfort-giving medication. (He will probably force me to lie down, ignoring my protestations and increasing my chances of dying of pulmonary edema).

If I get to the CCU while still alive, my chances of pulling through are wondrously increased compared to 35 years ago *but only* if my doctor is wise enough not to insist on giving

me personal care, but instead delegates his functions to the impersonal monitoring devices and to the bureaucracy of hospital employees, who, although they may lack his wisdom, are in a position to administer boli of lidocaine and electric shock when I need it, all on a regimented basis.

These verbal caricatures are intended as illustrations of what I believe lies at the bottom of the present conflict between medicine and society, namely a confusion of roles.

This confusion affects medicine as well as society and is most likely due to the great changes which have occurred in both segments at so rapid a pace as to make it difficult for individuals to make adequate adjustments spontaneously.

There is still a need for physicians to play the role of the wise counselor (father figure) to those who find themselves temporarily in a dependent situation because they perceive themselves to be singled out by nature to suffer more than others.

But there is also a need to make medical care or cure available on an impersonal basis whenever such an approach seems most likely to prove effective. In this situation a physician's role may be that of a scientific expert, that of a technician, or that of a manager (bureaucrat), depending on whether his knowledge, skills, or attitudes are required. In this situation, the physician is not a father figure and the patient, instead of being dependent, contracts for the psysician's expert opinion, his skills, or managerial knowhow.

Both roles are professional; they transcend limits imposed by specialties. In either, the patient may be a single individual, a family, a community, or even a governmental unit.

Physicians may have to play both roles at different times even for the same patient. To be effective, however, it is not enough for a physician to be merely good at playing these roles. He must be sensitive to recognize which role is called for and be conscious of which one he is playing at any one moment. The setting in which he works must be made supportive of these different roles so that the patient does not become confused. Finally, these roles must be taught in medical school and in graduate medical education programs as an integral part of academic education and specialty training.

In summary, we should accept the fact that there exists a conflict between medicine and society, but we should reject the natural reaction which is to look for villains both within and without medicine as the cause of this conflict. If we understand the various roles which we are called upon to fill in society and play them well, harmony may well be restored and we may then be able to lead the society which licenses us and supports us to new vistas. Plus Ultra!

Ira Marks '59

The basic problem in medical care today is not, as most seem to feel, the system of financing this care, but rather its nationwide delivery. What the American public desires and deserves is sufficient primary care, principally through physicians who are adequately trained, personally concerned, and available to help when help is needed. To accomplish this end, we must increase the number of service-oriented primary care physicians and then keep them happy in their work, whatever the financial process involved. No system will succeed otherwise.

However, government and academic medicine, the two groups with the power, time, and influence to produce the changes necessary, cannot move without undermining their own basic approaches to problem solving. The government bureaucracy thinks only in budgetary terms, and academic institutions proceed in terms of centralized sub-specialty care. Both thereby, neglect the personalized care crucial to the public and to the good practice of primary care medicine.

To reach this goal, I would suggest that we begin by emphasizing again the art of medicine. Physicians must be educated above all to serve patients. Years ago (and perhaps even now) students applying to medical school, when asked why they wanted to be a doctor, frequently said, "To help people." As trite as this aspiration seems, no organized solution to the problem of medical care will succeed unless those directly involved in patient care have as their prime motivation not status, nor money, nor mass screening, nor blood work, but simply helping the patient. Even if society in general remains overly organized and selfish, and individuals, including physicians, continue to share in these same tendencies, we must still emphasize service. We must encourage those interested in service to become physicians. Concurrently, ways must be found to enable them to practice medicine and at the same time satisfy their own personal needs for self-indulgence. Granted this is a big order, but we must move in this direction if we desire to increase the quality and quantity of medical care that is actually available to the general public.

Once students are accepted into medical school, they should be exposed to increasing amounts of the day-to-day practice of medicine. Certainly basic sciences are to be digested. Of course sub-specialties should be viewed. But the emphasis must be on the primary care of the patient whenever he is ill and not just on those aspects of care which will lead him into the hospital or to sub-specialty care.

To accomplish this, we must dramatically enlarge the outpatient services of our teaching hospitals and establish them as the fundamental educational facility of these hospitals. Qualified primary care physicians should be encouraged to teach at these facilities and residents and/or full-time personnel of these institutions should "cover" the practice in an exchange. This would be educational for all involved. It would allow students and full-time house staff a more realistic contact with

primary care and, if the practicing physicians were well chosen and motivated, a significant positive exposure to the challenges and satisfactions of primary care. Moreover, if the OPD's were not adequate to the job, then increasing use of "non-academic" hospitals and even doctors' offices would and should be arranged to adequately exhibit the true spectrum of primary care. At the moment, this spectrum is usually seen by the student and house officer through the academicians who rarely have ever done primary care. If we are to increase the number of physicians who will become practitioners, such an academic viewpoint must be at least balanced if not outweighed by direct contact with primary practitioners. And if medical schools are interested in developing primary care physicians, they must not only expand the use of practitioners for teaching purposes but include them (which Harvard has not done) in such groups as their curriculum committees.

However, even if we do produce increasing numbers of M.D.'s who want to deliver primary care, how can we keep them practicing where they are needed? It is here that the selfish human desires of even service-oriented physicians must be realistically dealt with. These needs would include adequate time off as well as sufficient remuneration, office facilities, and ancillary assistance.

To achieve adequate time off, physicians must be so situated that they never practice "alone." This does not necessarily mean they must practice in large groups or that solo practice must cease, but only that the truly isolated practice must be actively discouraged. In rural areas, it would be better to supply transportation to the patients to get them to a medical facility than to encourage "one doctor" towns.

Office facilities and ancillary care should be considered with the physician's income as part of the general cost of delivering primary care. And, of course, the costs to the nation would necessarily include hospitalization, transportation, education, research, etc. The sum of all such medical expenses is and will be so great that government and/or insurance plans will become the primary financier of such care. Nevertheless, whatever prepaid insurance system we eventually settle upon, I feel the patient should pay some portion of each service rendered. Such direct involvement with the cost of care might help to control a physician's tendency to unnecessarily test or treat as in a situation where the lab and drug charges are "free." Moreover, it might help to remind people that "free" medical care must be paid for by someone.

This is not to be construed as a mandate for huge incomes for physicians, but rather that in addition to a baseline "salary" whose funding will be some form of prepaid insurance, there also will be a fee-for-service charge. The salary would depend on training and area of service; the patient's "fee" could depend on the service involved and his own income. In areas where the patients could afford less or which, for whatever reason, seemed to attract fewer physicians, the "salary" or "free time" might be increased. Correspondingly, if there was a surplus of researchers, or pediatricians, or surgeons, their salaries or free time might be reduced.

Who will determine these baseline salaries and free time incentives? Here we have no choice but to institute some sort of bureaucracy. However, whatever panel or commission is set up, it should include lay people as well as a representative spectrum from the medical profession. And although a national coordinating group would be necessary, basic decisions should be left to state or regional groups. We must remember that the authority held by such a panel will be no greater than that now held by many branches of government vis-a-vis teachers, truck-drivers, policemen, and in fact, all employees of government. More specifically, although the panel would seem to have great power, it would be balanced by the need for the service involved.

In addition, both those involved in medical care and the public must somehow come to terms with society's increasing demands for the delivery of medical services. No plan is going to prosper as long as the general population believes every ache deserves a pill and every fever a shot. Educating the public to accept some discomfort without calling a physician should be one of our primary goals. If, however, our social customs are such that this is an impossible aim, then even further organization of primary care will eventually be required. The development of "feldshers" or physician screening assistants will become a necessary added expense and facet of the total delivery system. And the training of such professionals would be essentially clinical — a further reason for massive expansion of our "outpatient" teaching facilities.

Finally, what any citizen really wants (and needs) when he is ill is to have someone he can call upon for proper assistance. My proposals for change within the present medical care system are motivated by the desire to see that assistance provided. I believe that any eventual reorganization of medicine that does otherwise will be a failure.

Samuel G. McClellan '44

Having just finished reading the March/April HMAB, I hasten to act on your invitation to comment on its contents. Allow me to respond, first, to your editorial reaction ("A Contest for HMAB Readers") to Michael G. Michaelson's introductory essay. I sincerely hope that you err in estimating that " . . . his viewpoint is, of course, alien to that of the majority of our alumni." I, for one, was not alienated by Mr. Michaelson. Rather, I must confess, I was a bit tickled by his not too unfriendly pokes at your journalistic and our collective Harvardian, ribs, and found myself pulling out past issues of the *Bulletin,* scarcely glanced at before, for more careful perusal

(surely a constructive reaction more akin to persuasion that polarization). I regard it as a healthy sign (sociologically speaking) that there exists today a radical people's health movement, with articulate spokesmen such as Michaelson and Levy, to counterbalance the conservative (AMA) and liberal (medical school-teaching hospital) influences on the direction the health industry will take in the immediate years ahead. You are to be heartily commended for presenting their views in the *Bulletin* despite your apparent discomfort in doing so.

I offer some testimony from my experience during the past four years as a staff member of the Martha Eliot Health Center, mentioned on occasion in past numbers of the HMAB, a neighborhood health center (NHC) which now has four Harvard teaching hospitals for its benevolent "parents." Having been born near the beginning of the NHC era, I imagine it could stand as a "classic" example of a federally funded, hospital related, urban health center serving a largely poor, minority group population. Hours upon hours of meetings have taken place, many of which I have attended, where the subject was the desirable and feasible extent and nature of community participation in policy level decision making for the center. The chief participants at these meetings have been the medical director of the Martha Eliot, the chief administrators of the parent hospitals (or their representatives), and a small number of self-appointed spokesmen for the community served by the center. What to me has become crystal clear is that in the protracted and still unresolved power struggle which these meetings reflect, there are two groups of people whose views are not being solicited and whose interests the active protagonists seem quite content to ignore. They comprise the generality of our patients, on the one hand, and the primary providers of health care at the MEHC (doctors, nurses, etc.), on the other. This is precisely the kind of situation which the radical health movement folks are criticizing, and the frustration of sweetly reasonable efforts to change which induces exaggerated rhetoric, confrontations, and the like.

Randolph Reinhold's story of the creation of the Roxbury Dental and Medical Group, Inc., and of the problems it has encountered, I found the most interesting article in this issue. He, also, makes the point that extension of the hospital OPD into the community via the NHC does not, necessarily or usually, affect any significant change in the "system," with its "authoritarian, manipulative, bureaucratic, and anti-democratic" defects. Especially intriguing was the brief allusion to the establishment of a community corporation which seemingly took over, with little strain on either side, the control of RDMG. Though Reinhold may not have told the whole story of this accommodation between medical group and community, the fact that it was achieved is of great significance considering the failure of some medical schools and hospital institutions to accomplish the same feat.

The ultimate challenge for RDMG, as for all NHC's serving a predominantly poor population, is that of financial survival without dependence upon government grants or some other external, potentially controlling source of funding. This is inseparably bound up with what Reinhold correctly, I believe, identifies as an issue central to all those facing the medical profession today, ". . . the question of individual flexibility versus organizational and governmental control" — since it is still true that he who pays the piper calls the tune. It is widely assumed that the next few years will see an approach to this economic problem being made by the federal government through some form of national health insurance. It seems inevitable that this will also fail to alleviate the fundamental malaise of our health care "system," for the only solution, I think, to this aspect of our difficulties lies in the establishment of a more far-reaching national program and procedure for the redistribution of wealth and income among our citizens than has yet been publicly espoused by anyone in national office. I am thinking of a thorough reconstruction of our entire tax system with its future foundation being a graduated income tax, having both negative and positive components to its total schedule and a zero point set high enough to permit everyone to purchase his own medical insurance or prepaid health care program for himself.

Sanford I. Roth '56

Though I am deeply disturbed by the innuendo, half truths, and untruths in the article by Howard Levy, one statement I feel all too well typifies the radical philosophy. The statement "the ends sometimes justify the means," cannot be allowed to go unchallenged. It was this philosophy that Hitler used to justify the mass murder of the Jews, that Stalin used to justify the murder of the Kulacks, that Mao used to justify the murders of the cultural revolution, and that Ho used to justify the murder of those Vietnamese who disagreed with him as documented by Tom Dooley. No program, no matter how lofty its goals, or how wonderful its results, can ever justify unethical methods or means, and when Levy uses that expression, he is not speaking of democracy but of dictatorship.

William G. Winter '63

I wish to congratulate the *Alumni Bulletin* on publishing the thought-provoking contributions by Michaelson and Levy, and plunge into the water myself for a few brief observations. I write as a still-maturing young physician, nine years out of Harvard Medical School, a specialist who still has not lost touch with the poor. I will match my support among my patients with Dr. Levy's.

Mr. Michaelson's article is stimulating — my copy has my pencilled notes on every margin — but immature. I plan to read the references

he recommends, but write only in reaction to his *Bulletin* article.

I feel certain that valuable and viable concepts *will* emerge from the People's Health Movement and its congeners. Indeed, when Dr. Levy speaks of active consumer participation in medical delivery systems, I am tempted to see a net benefit to my profession. Intelligent, informed non-physicians working hand-in-hand with physicians of similar potential may make a far better job of quality review than we physicians can alone. I am quite willing to submit my own product to such review.

Nonetheless, both the delivery of top grade medical care and the structuring of its systems of delivery are exceedingly complex and challenging tasks, as witnessed by the difficulty highly trained "delivers" (i.e., most of us) encounter when they try to alter the "systems" of delivery. I am concerned lest the melting pot membership of the People's Health Movement presume too much. "Credentials" — backed by intelligence, judgment, and drive and, indeed, created by them — are *good*, not bad. "By your works ye shall be judged."

As one who still actively contemplates both the world of private practice and the world of the university center, I confess to perceiving many of the faults of both cited by authors Michaelson and Levy. I expect the university can and will defend itself with intelligence and good intent. I fear, however, that the radical health movement does indeed tend to see the world of private practice in too flat a profile, and I choose to make a few remarks in its defense.

How are we to better a system which has historically restricted entrants to highly intelligent and/or hard-working individuals, has then tried to imbue in them a sense of ultimate responsibility for their patients, and has then rewarded them for the quality and quantity of their work. The immature physician assumes that consumers are too uninformed to choose their care intelligently. That is only half-truth. They may sometimes be at the mercy of a system which offers too few physicians (due greatly to uneven distribution) to choose. They may, on occasion, mistake kindly concern for competent care — but creative structuring of peer review could alter that. Furthermore, human happiness may oft be as well served by kindly concern as by efficient but cool competence. The care of the patient still begins with care for the patient. In my opinion, good doctors rapidly become known as such to anyone who makes inquiry.

Which brings this communication to money. I truly admire the idealism of those great men and women for whom money is in another dimension, perhaps even obscene, as Mr. Michaelson implies. I pity, however, their families. I question their ability to deliver a product or organize a system (e.g., of health care) in a world where such idealists are likely to ever be a small minority. We live in a society where aggressive, hard-working, and intelligent men in many skilled trades and professions may make from $20 to $50 an hour, working "banker's hours" at that. I want medicine to have its share of the best young men, willing to work 60 or more hours a week, get up at night to care for the results of mixing booze with motorcycles, and still offer his wife and family some tangible reward for the loss of his conjugal consort. Furthermore, I want those physicians to be motivated to continue the active, efficient, caring practice of medicine in their thirties and forties when the flame of idealism must withstand the winds of reality — of educating children optimally; of paying 40 percent overhead and up to 50 percent in taxes on the remainder; of houses whose plumbing repairs cost $15 an hour, plus parts.

Mr. Michaelson speaks of a sophisticated public which will demand free medical care, medicine, access to medicines, and to medical tools. He and I see reality very, very differently. Free? Mr. Michaelson will, I feel sure, mature to a different view before too many years have passed. The essence of sophistication should be seeing things as they are. Let Mr. Michaelson show me a way to continuously deliver top quality *anything* for free. I suggest, rather, that all sophisticated humans are instinctively aware of this old farm adage. If you can be satisfied with hay that has passed once through the horse, that comes cheap. If you want nice fresh hay, that will come a little higher.

Nonetheless, I welcome Mr. Michaelson's willingness to voice his ideas. I have learned much in courage from him, Dr. Levy, and their peers. Perhaps we can meet further, in print or in person, to confront, to argue, to make it together, as he says. Ideas are like race horses. You must test them on the track before you know their worth. Out of the dialogue will come the answers.

Henry H. Work '37

When Axel Munthe was practicing in Paris, he found his clientele composed almost entirely of wealthy, hysteric ladies with whom he was an instant success because of his dramatic personality. By his own account, he found this boring and soon left to return to his native Lapland and eventually to Italy. One infers, between the lines of his book, that he developed a sort of community health practice as opposed to the more lucrative private practice that he had enjoyed in Paris.

This early example of a shift to a community model represents more than merely the process of the practice of medicine. It represents also the fact that the manner of practice, despite one's knowledge and background, is not entirely dictated by external events or social concerns. Individual capacities, personal backgrounds, and personality traits are equally important. One has only to look at the output of any class at Harvard Medical School to see the fantastic range of interests, disciplines, and practices that come out of the common core of learning during a four-year experience.

It suggests that the personalities

of individuals going into the field of medicine have a great deal to do with shaping the manner in which they will carry out their tasks subsequently. It also suggests that not everyone is prepared to do all forms of medicine and particularly not able to shift to newer forms of practice and health care.

As an observer of the field of pediatrics for the last 25 years, I have become awed with the chronic and repeated exhortation that pediatricians should practice a comprehensive kind of care once described by Bronson Crothers as care for the "whole child." It is my personal conclusion that this exhortation in itself means something. It suggests that not everyone is able to change his mode of practice to a wider base, not because of lack of knowledge or because of the financial returns, but rather from some internal psychological processes. The current exhortation to get away from the bed, from the laboratory bench, and even perhaps from the more organized outpatient clinic is not easy for all physicians to follow. The capacity to follow the urgings of radical groups may depend as much on something in the personality of individuals that go into medicine as that which is taught to them during the process. Part of this early selection may be occurring in the seemingly more idealistic students that are coming into medicine. Part of it could be affected by admissions committees who would choose a different kind of student.

It is my feeling that to think either clinically or sociologically about the problems which we must face and to neglect the basic personality necessary for carrying out these procedures, is foolhardy. It is easy to take issue with the biases of various trained men in the field of medicine. It is more important to consider the origin of these biases, to see how they can be shaped early in the careers of individuals, and then proceed to shape the new world of medicine around a core of individuals whose personalities are appropriate to the shaping.

Alumni NOTES

1914

Harold W. Stevens writes: "Continuing pursuit of community action projects from 'head start' to 'aging.' 'Delegate at large' in White House Conference on Aging, 1971. A re-energizing experience; highlighted by a happy reunion with Paul Dudley White '11. Follow-up of WHCOA promises my major drive for duration. For intellectual renovation re-reading P. D. White's *My Life In Medicine,* and Carl Binger's *Thomas Jefferson, A Well Tempered Mind;* for spiritual regeneration, studying Apostle Paul's *Mystery of the Gospel* (Eph. VI); for self discipline in all things, Robert Browning's *Vitamines,* 'A man's reach should exceed his grasp, or what's a Heaven for?' "

1915

Horace K. Sowles is "just living in quiet retirement and when [he] reflects on the world's problems, [he] is convinced that [he] has lived in the golden age."

1917

Karl A. Menninger writes: "Am retired from the clinical work at the Menninger Foundation but continue to give what help I can to the reform of the prison system and the abolition of local jails. There is a gratifying widespread effort on the part of many people to accomplish these things. We are all proud of Massachusetts for having abolished the iniquitous juvenile prisons called reformatories and other euphemistic mislabels . . . My official stance for helping along some of these things is membership in the State Board of Corrections of the state of Illinois and of the special committee on corrections of the American Bar Association."

1920

James Hitchcock writes: "Retired: loafing: trying to get the USA under control: my slogan, 'Do the people of this nation want a government of Richard M. Nixon, by Richard M. Nixon, and for Richard M. Nixon?' "

1921

Elmer L. Severinghaus and his wife have established their residence at Captive, Florida. They have had a winter vacation home there for 17 years. Summer months will be spent partly in Conn., and with their three children on the west coast.

Philip D. Woodbridge plays viola in two orchestras. He deeded 30 acres of woodland to Greenfield, Mass. for a wildlife preserve, and felled the trees on the remaining 20 acres for firewood. He is working "for peace, learning to live within limitations of cardiac and circulatory disease."

1922

J. Minton Meherin is still in the practice of surgery with five surgical associates.

William H. Van Wart writes: "In my latter years, I am disturbed by the many ills that are present in our society today. I believe not the least of all of them is the fact we have too many arrogant, selfish, and greedy, intelligent people . . . who lack proper moral integrity. [They] take advantage of the uninformed for more of the 'almighty dollar' and 'political power.' I believe these people . . . with this philosophy of life are deteriorating the moral fibre of our society."

1923

Derrick T. Vail Jr. writes: "We